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The healthcare experiences and needs of migrant women affected by domestic violence and abuse

Seen but seldom heard: The healthcare experiences and needs of migrant women affected by domestic violence and abuse

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Abstract

Background: Domestic violence and abuse (DVA) is a significant health burden and often concealed in healthcare. Migrant women face specific barriers to access and within healthcare. This PhD sought to identify the healthcare experiences, support pathways and needs of migrant women affected by DVA.

Methods: A systematic review and qualitative synthesis of 27 publications were conducted, using elements of a meta-ethnography synthesis approach. Semi-structured interviews were carried out with migrant women (n=8) and various professionals (n=12). 19 interviews were recorded, transcribed verbatim and analysed thematically using the constant comparative method.

Findings: Both the synthesis and the interviews identified constrained help-seeking and help-receiving experiences due to lack of access and knowledge, immigration status and language barriers, as well as fear of consequences and potentially harmful responses, including breach of confidentiality. DVA severity and its impact on the health of women and children triggered disclosure, another condition for disclosure was trust. Person-centred care was perceived positively or desired, whether this may reflect a universal need or additionally requires cultural understanding is unclear. There is a need for adequate language provision and to improve access to mental health care. Additional training for healthcare professionals is crucial to improve their understanding of migrant women affected by DVA to facilitate appropriate help.

Conclusion: Research on migrant women and the role of healthcare professionals in their care has so far been sparse. This is the first qualitative synthesis on the healthcare experiences and needs of migrant women with DVA. This PhD begins to address this gap in research by developing novel ideas on possibly appropriate interventions and the potential role of healthcare services in DVA. This is highly important for both healthcare and policy.

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's *Regulations and Code of Practice for Research Degree Programmes* and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED: ..... DATE: .....

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Finally, and most importantly: I would like to thank all the women and staff who participated in my interviews. I feel privileged and grateful that you shared your stories and experiences with me. I hope this research will improve the healthcare response to migrant women affected by DVA.

Dedication

I dedicate this PhD to my late grandmother and the two men in my life: Carlos and Julian.

Key to Abbreviations

A&E	Accident and emergency
BME	Black and ethnic minority
BCS	British Crime Survey
CASP	Critical Appraisal Skills Programme
CBT	Cognitive Behavioural Therapy
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CSEW	Crime of Survey for England and Wales
CTS	Revised Conflict Tactic Scale
DART	Digital Archive of Research Theses
DHS	Demographic and Health Surveys
DoH	Declaration of Helsinki
DVA	Domestic violence and abuse
DV	Domestic violence
ED	Emergency department
EMBASE	Excerpta Medica Database
EMiNA	Evaluating migrant women's needs regarding domestic violence and abuse
ENTREQ	Enhancing transparency in reporting the synthesis of quality appraisal
EThOS	Electronic Theses Online Service
EU	European Union
FM	Forced Marriage
HDI	Human Development Index
HIV	Human Immunodeficieny virus
IDVA	Independent domestic violence advisors
IOM	International Organisation for Migration
IPV	Intimate partner violence
IRIS	Identification and Referral to Improve Safety
GBPV	Gender based partner violence
GNI	Gross national income
GNP	Gross national product
GP	General practitioner
HCP	Healthcare professionals
HDI	Human Development Index
HO	Home office
HV	Health visitor
MEDLINE	Medical Literature Analysis and Retrieval System Online
MeSH	Medical Subject Headings
n	Sample size
NHS	National Health Services
NICE	National Institute for Clinical Excellence
NIHR	National Institute for Health Research
NRPF	No recourse to public funds
OECD	Organisation for Economic Co-operation and Development
OpenSigle	System for Information on Grey Literature in Europe
PATH	Psychological Advocacy Towards Healing

PCRN	Primary Care Research Network
PIS	Participant information sheet
PTSD	Post-traumatic stress disorder
PV	Partner violence
RCT	Randomised controlled trial
R&D	Research and Development
SPCR	School of Primary Care Research
STD	Sexually transmitted diseases
TPB	Theory of planned behaviour
TTCM	Transtheoretical model of change
UK	United Kingdom
UN DESA	United Department of Economic and Social Affairs
US	United States
VAW	Violence against women
WMA	World Medical Association
WMR	World Migration Report
WHO	World Health Organisation

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Chapter 1: **Introduction**

Domestic violence (DV) is a human rights abuse and a global issue in public health and clinical practices (1); however, it often remains hidden and unaddressed in healthcare. (2) The overall aim of this doctoral thesis was to identify the healthcare[1] experiences and needs of migrant women affected by domestic violence and abuse (DVA)[2]. The objectives of my PhD research were to:

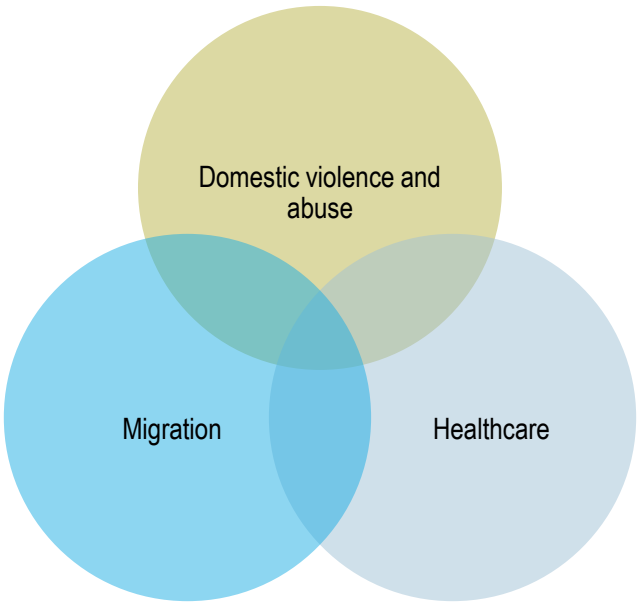
(1) Investigate migrant women's healthcare experiences;

(2) Identify how these women found support in healthcare;

(3) Identify any unmet healthcare needs of these women.

To address these objectives, I conducted two studies: (1) a systematic review and synthesis of qualitative studies examining the healthcare experiences of migrant women with a history of DVA and (2) interviews with migrant women affected by DVA, healthcare professionals (HCPs) and other professionals working with these women. Thus, this thesis examines the intersection of DVA, migration and healthcare, as illustrated in Figure 1.1 below.

Figure 1.1: Areas of focus of this PhD



[1] Definition: '*the organised provision of medical care to individuals or a community*'. https://en.oxforddictionaries.com/definition/healthcare

[2] I will use the acronym DVA throughout this thesis. DV (domestic violence) will also be used interchangeably with DVA.

The aim of this chapter is to provide brief definitions of DVA, migration, culture, and help-seeking. I will then discuss the prevalence and impact of DVA, as well as the explanations for DVA, with a focus on intersectionality and culture. Following this, I will examine help-seeking for DVA and identification in healthcare. Finally, I will provide an overview of this chapter and subsequent chapters.

1.1 Definitions

In the next sections, I will briefly provide the definitions of DVA, migrants, culture and help-seeking.

1.1.1 Definition of DVA

DVA is one form of gendered violence against women (VAW).[3] The United Nations Commission on the Status of Women (4) defines violence against women in article 1 as

> *any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.*

The Violence Against Women movement was almost entirely centred on interpersonal violence (5) – that is male-to-female violence between adults in previous or current intimate relationships. There are multiple terms denoting this type of violence, namely: domestic violence (DV), domestic abuse, intimate partner violence (IPV), partner violence (PV), intimate partner abuse, battering, wife-beating, and spouse (or spousal) abuse[4]. However, this definition lacks international, or even national, consensus as no agreement exists regarding which term most appropriately describes this particular kind of violence (6); there is a debate, among experts, on whether the term 'domestic violence' is misleading as it implicates violence only occurring in homes. (6) Some experts, in turn, strongly disagree that an abusive relationship can be labelled 'intimate'. (6)

DVA comprises many forms of violence, such as physical (ranging from slaps, punches and kicks to murder), sexual (e.g. forced sex or participation in sexual acts), emotional abuse (e.g. ongoing belittlement, humiliation or intimidation), economic restrictions (e.g. preventing a woman from working, or confiscating her earnings), other controlling behaviours (e.g. preventing a woman from having social contacts). (7) Frequently, these forms of domestic violence are found to coexist. (7, 8)

[3] It should be noted that DVA does also affect men, although women experience it more often and more severely. (3)
[4] I will also use the authors' terms, such as intimate partner violence (IPV), specifically when referring to their studies.

The governmental definition of DVA in the United Kingdom (UK) is:

> *Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional. (9)*

This definition explicitly encompasses violence and abuse between family members and between parents and children over the age of 16. Thus, this term extends the scope beyond intimate partner relationships and covers, for instance, forced marriages (FM) and other forms of violence, which may also be carried out within a family. The definition recognise DVA in young people aged 16 and over. Yet it also overlaps with child abuse as FM can occur before the age of 16. Although the UK definition widens the scope to include perpetrators and violence, it does not recognise violence by wider community members that, in mainstream Britain, are not perceived as family. (10) Nonetheless, according to criteria set by Humphreys and colleagues (11), the above definition can be judged as good, as it is a) inclusive and acknowledges diversity; b) includes different types of abuse (e.g. physical, emotional, sexual etc.); c) recognises diverse experience (e.g. including violence from the wider family) and d) includes gender and interconnected power and control issues.

1.1.2 Definition of migrant women

Migrants make up 244 million people, or 3.3% of the world's population; half are females. (12) Over 22 million people are refugees[5]. (12) Analyses of migration often use a push-pull model: push factors, such as economic or political conflict, cause people to leave their country, while pull factors attract people to a country. (12) There are also gender[6]-specific reasons for migration, such as escaping violence (e.g. rape). (13, 14) The United Nations Human Development Report proposes that migration can benefit people by facilitating more economic and educational opportunities (15); however, migrants notably also frequently encounter barriers to, for instance, local health and social services. (16) Below I will discuss issues surrounding the term 'migrants'.

[5] Refugee: A person who, 'owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.' (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A (2), 1951 as modified by the 1967 Protocol). https://www.iom.int/key-migration-terms#refugee

[6] Gender is a socially constructed term used to describe the characteristics of women and men, whereas 'sex' refers to features that are biologically determined. '*People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles*' (WHO http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/gender/gender-definitions)

The terms 'migrant', 'immigrant', 'migration' or 'immigration' are not clear-cut. There is no consensus regarding a *single* definition of who constitutes a/n (im)migrant. (17)[7] In Latin, *migratio* means movement *and migrāre* means to move from place to place, change position or to change one's abode. To immigrate defines that a non-national moves to a country to settle, while to emigrate means to leave one state to settle in another. (18) So far, there is no agreed system for classifying migration, 'race'[8], ethnicity[9] and culture, particularly across countries. (21) Hence, there are many different definitions and the terms 'migrant', 'immigrant', and 'foreigner' are often used interchangeably. (21) As with all definitions, this affects data specification (17); for instance, diverse migrant and ethnic groups are often collapsed into one category, such as 'Hispanics' and 'Asians'.

The United Nations' definition denotes a time dimension of 12 months to become a long-term migrant and the country of destination becomes the new country of usual residence. (22) The International Organisation for Migration (IOM) (23) defines a migrant:

> *as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is.*

Thus, in the above definition, the scope for migrants not only includes people who migrated voluntarily,[10] but also refugees and asylum seekers.[11]

Some migrant classifications extend to descendants of migrants. For instance, in Germany, the term 'migration background' is a defining criterion in German official statistics to describe a population composed of migrants and their descendants since 1950. (24) In Britain and other countries, 'ethnic background' is used in a similar fashion. The

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7 In British law, there is no definition of migrants or immigrants; the only distinguishing feature is the 'right to abode' in the UK (i.e. all British citizens, as well as a small minority of Commonwealth citizens and, currently, EU citizens). People who have not got the right are 'subject to immigration control'. (17)

8 The term 'race' is a highly contested term. Historically and commonly, it was and is used to refer to a group (subspecies in traditional scientific usage) a person belongs to through '*a mix of physical features such as skin colour and hair texture, which reflect geographical origins, historically as identified by others or, increasingly, as self-identified. The importance of social factors in the creation and perpetuation of racial categories has led to the concept broadening to include a common social and political heritage, making its usage similar to ethnicity. Race and ethnicity are increasingly used as synonyms, causing some confusion and leading to the hybrid terms race/ethnicity*'. (19)

9 'Ethnicity' is derived from the Greek word '*ethnos*', which means 'people' or 'nation' (20). Bhopal defines it as '*the social group a person belongs, and/or are perceived to belong to, because of certain shared characteristics, including geographical and ancestral origin, but particularly cultural traditions and language*'.

10 However, it could be questioned here, whether needing to leave one's own country for economic reasons (e.g. poverty) can be 'entirely voluntary'.

11 'Asylum seeker' describes a person '*who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other grounds.*'
https://www.iom.int/key-migration-terms#refugee

commonality between migrants and subsequent migrant generations or ethnic minority groups is a history of migration, which – although at times rather distant – can still impact subsequent generations (e.g. regarding citizenship, legal status, racism, discrimination and poverty). (24, 25) However, migrants and ethnic minorities *do* differ regarding other factors, such as having lived in the country of residence for generations.

For this thesis, I decided to define 'migrant women' as women who were foreign-born to foreign-born parents (i.e., for instance, no British citizenship or nationals) and these migrant women had migrated for various reasons (i.e. for economic reasons, to escape war etc.). The duration of residence in the new country of residence was not time-restricted – that is, it could be very short (e.g. they had just arrived in Britain) and no upper time limit was set (e.g. a woman from India who had lived in the UK since the 1960s or longer).

Migrants are not considered a homogeneous group (26), even if they come from the same country. There can be numerous differences regarding, for instance, educational background, socio-economic status and legal status, language, religion, and age at migration[12]. (29) Here, I wanted to examine different migrant groups to conceptualise how migration-specific factors may impact women's DVA and healthcare experience. By doing so, I do not deny the heterogeneity of migrant women and do not want to oversimplify their diverse histories, cultures, contexts, experiences and perspectives. Instead, I wanted to discover both commonalities and differences in their experiences to advance theorising across different migrant groups (30) and to inform policy and practice by making, for example, recommendations for suitable generic or tailored interventions. Thus, in my synthesis and interviews, where possible, I will consider the country of origin, age at migration, length of stay in the country of residence, linguistic proximity, and legal status.

1.1.3 Defining culture

The concept of 'culture' is often used in discussions of DVA and migrant women. Culture, originally referred to cultivation of land (31) (from Latin *cultus* cultivation, from *colere* to till) (32), and now refers to human society. This term has been defined in abundant, and often contradictory, ways that have changed over time. (33) According to Hall (34), culture is one of the most difficult and multifaceted concepts in human and social sciences. Edward Tylor, an English anthropologist, proposed a prominent definition of culture in 1871:

> *Culture or Civilization, taken in its wide ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. ((35) p. 1)*

[12]Age at migration is often not considered when studying migrant populations, although it can influence how well an individual can adjust to the new country, language, and culture. (27, 28)

This definition, particularly '*that complex whole*', was described by Clifford Geertz, an American ethnographer, as a 'conceptual morass' and since gave rise to many more definitions. (33) According to Tylor's (35) and others' understanding, culture was '*a conscious creation of human rationality*', where culture and civilisation were seen to tend to progressively develop greater moral values (36) in an evolutionary model, which was closely linked to 'race'. (31) Based on this, a hierarchy of cultures or civilisations was constructed, which served as a justification for the colonisation of lower-order countries by apparently higher-order Western civilisations. (36)

The father of modern cultural anthropology in the US, Franz Boas, a German-born American anthropologist and cultural relativist, critiqued these evolutionary models at the turn of the century. (37) Boas proposed that cultures did not develop '*according to evolutionary stages, but in response to historical circumstances, including the diffusion of ideas or cultural traits from other cultures'*. (36) Boas proposed that '*culture should be understood in terms of its own framework of meaning rather than being judged by outside investigators according to the values of their own culture*' (36). For Geertz, the concept of culture is essentially a semiotic one. (33) I used a combined definition of culture here:

> *Culture is concerned with the production and exchange of meanings – the 'giving and taking of meaning' –between the members of a society or group. ((34) p. 2) It incorporates all the shared knowledge, customs, values, expectations and beliefs of a group at a specific time that is acquired by human beings through their membership of a society. This accumulated knowledge is passed on by means of symbolic systems such as language. (38)*

This definition also captures Boas' notion of diffusion: cultures are not fixed.

1.1.4 Defining help-seeking behaviour

There is no clear-cut definition regarding help-seeking or help-seeking behaviour. Help-seeking in healthcare can be understood as an adaptive coping process, used as an attempt to obtain external assistance to deal with a health concern. (39) It can also be understood as a complex decision-making process triggered by a '*problem that challenges personal abilities*' (39) and defined as *'a problem focussed, planned behaviour, involving interpersonal interaction with a selected [healthcare] professional'*. ((39) p. 280) However, this definition is not unambiguous as will be further discussed.

In summary, the definitions of DVA, migration, culture and help-seeking are complex and sometimes contradictory. None of these definitions are unequivocal and final, yet they impact measurement, which I will discuss below.

1.2 Prevalence of DVA and its impact

In the following, I will summarise the prevalence of DVA in women, before moving to prevalence in migrant women[13].

1.2.1 DVA prevalence

The 2017 Crime Survey for England and Wales (CSEW) in England and Wales reported that a quarter of women aged between 16 and 59 had experienced domestic violence and some form of domestic abuse since the age of 16. (40) Moreover, an estimated 7.5% of women (1.2 million) had experienced domestic abuse in the last year. (40) The last Demographic and Health Surveys (DHS) report in 2016 found in their nationally representative data on domestic violence that the highest rates were found in Uganda (47%), and the lowest in Cambodia (19.9%), for IPV in the last 12 months; this increased for Uganda to 58.8%, and Cambodia to 27.6%, for any experience of IPV. (41) The most recent EU survey covering 28 members states found that '*just over one in five women has experienced physical and/or sexual violence from either a current or previous partner*' in their lifetime. (42)

Although domestic violence has elicited world-wide research, few have examined domestic violence specifically among migrant women. Some studies suggest that migrant women may be particularly vulnerable to DV as they encounter it more frequently and more severely. (e.g. (8, 43)) In Germany, the lifetime prevalence for physical and/or sexual violence from previous or current partners is greater among Turkish-born women aged 16 to 75 years (37%) and migrant women born in the former USSR (27%), when compared to German women (26%). (44) Here, migrant women were also found to suffer from more severe forms of physical and sexual violence, which also resulted in more severe injuries. (44, 45) According to Raj and Silverman, migrant women experience DV in epidemic proportions (46, 47) – although this is disputed. Some suggest economic factors are the key underlying cause for differences and, when these factors (primarily socioeconomic status) are controlled for, this effect disappears. Other studies did not find any differences between migrant and non-migrant women: The British Crime Survey in 2001 (48) found that ethnicity explained the small variation in domestic violence; however, the most recent Crime Survey for England and Wales (CSEW) data shows that mixed ethnicity women '*were more likely to have experienced partner abuse in the last 12 months than any other ethnic group*'. ((40) p. 7). However, here it cannot be determined whether these mixed ethnicity women were migrant women and the possibility of differential under-reporting may account for differences between migrant and non-migrant populations. (48, 49)

[13] I focused on high-income countries to make the healthcare experiences of migrant women comparable. The reasons for this will be further explained in the next chapter.

A representative Canadian cross-sectional study suggested that there may be a difference between migrant women as to the length of residence. (50) Hyman and colleagues (2006) (50) found women, who had recently migrated from so-called non-traditional source countries, such as Asian/African countries, who had lived in Canada for less than ten years, experienced less intimate partner violence than migrant women from traditional source countries (such as the UK), who had lived in Canada for more than ten years. However, in this study, two heterogeneous migrant groups were compared with one another; these not only differed in cultural respects and acculturation, but also in terms of socio-demographic characteristics – such as education and linguistic proximity (e.g. women from the UK who migrated to Canada). Non-disclosure of violence on the part of recent migrant women may have accounted for the observed different rates of partner violence. It should also be noted that this study was a telephone survey and the interviews were conducted in English and French only. It can, therefore, be assumed that not all migrant women could be reached due to, for instance, lack of access to a telephone, coercive control or not being able to speak either language. However, it is noteworthy that this was one of the few studies including Western European migrant women, who are seldom classified as migrants (e.g. instead called expatriates or Commonwealth) and are, thus, absent in literature.

Data on the prevalence of domestic violence indicates the scale of the problem – namely its prevalence and frequency – although only few cases are reported to the police. (48, 49) Surveys may not capture the true prevalence of DV as it is a highly sensitive subject that is not readily disclosed to strangers. (7) There are few representative surveys on violence against migrant women in current literature. (51-53) The surveys have many methodological discrepancies regarding the definition of migrants which mirrored what was said earlier. There is no consistent definition employed throughout Europe. (53) Furthermore, the age range, definition and measurement of violence (e.g. life experience vs the last 12 months) also differ. (52, 53) Additional 'cultural' forms of violence, perpetrators (such as the extended family) (46, 54) and contexts of domestic violence affecting migrant women are generally not measured in the survey instruments. There are also ethical issues, such as accessing women safely (which may particularly apply to migrant women), getting informed consent and conducting interviews in the native languages of migrant women. Moreover, migrant women, particularly undocumented migrant women, may refuse to take part in research due to fear of deportation.

1.2.2 Health impact of DVA

The World Health Organisation (WHO) declared DV as one of the world's biggest health risks for women and children. (1, 55) The health outcome can be fatal, either directly through homicide or, indirectly, through suicide. (1, 55) The physical and psychological

health consequences are far-reaching and serious for both the individual and society in the short, medium and long-term instances. (56) The following table (Table 1.1) summarises the health consequences of domestic violence:

Table 1.1: Health consequences of domestic violence

Fatal outcomes	Physical injuries and chronic conditions	Non-fatal outcomes: Sexual and reproductive sequelae	Psychological and behavioural outcomes
Femicide Suicide AIDS-related mortality Maternal mortality	Fractures Abdominal/thoracic injuries Chronic pain syndromes (Fibromyalgia) Gastrointestinal disorders Irritable bowel syndrome Lacerations and abrasions (Ocular damage) Burns Ear injuries	Gynaecological problems Pelvic Inflammatory disease Sexually transmitted Infections, including HIV Unwanted pregnancy Pregnancy complications Miscarriage/ low birth weight Sexual dysfunction Unsafe abortion	Depression and anxiety Eating and sleep disorders Drug and alcohol abuse Phobias (and panic disorder) Poor self-esteem Post-traumatic stress disorder Psychosomatic disorders Self-harm Unsafe sexual behaviour

Source: Adapted from Ellsberg ((57) p. 1)

Women who experience DVA often obtain injuries to the head, face, neck, thorax, breasts and abdomen. (58) Many health problems seen in the clinic are, therefore, associated with DV. In comparison with non-abused women, abused women often go on to experience gynaecological problems, such as sexually transmitted diseases (STDs), vaginal bleeding and infection, genital irritation, chronic pelvic pain and urinary-tract infections. (59) Other conditions often associated with DVA include chronic pain (e.g. headaches, back pain), central nervous symptoms (e.g. fainting and seizures) (59), self-reported gastrointestinal symptoms (e.g. loss of appetite, eating disorders) and diagnosed functional gastrointestinal disorders (e.g. irritable bowel syndrome). (59, 60) Aside from injuries, fear of and stress from domestic violence may also cause chronic health conditions, such as pain (e.g. headaches). (59, 60) While the exact mechanisms through which DV indirectly impact health remain unknown, they are thought to include recurrent injury or stress and damage to neurophysiological pathways. (59)

DV impacts mental health severely: depression and post-traumatic stress disorder, which have a substantial co-morbidity, alcohol abuse and drug dependency are the most prevalent sequelae of DV. (61-69) Golding (69) (1999) found, in a meta-analysis, that depression and post-traumatic stress disorder (PTSD) were more prevalent in women suffering from domestic violence than in women who were sexually assaulted in their childhood. In a more recent meta-analysis, it was found that women with depressive disorder, anxiety disorders, and PTSD had a greater risk of experiencing lifetime partner violence when compared to women without these mental health conditions. (61) Coid and colleagues (2003) (70) further found that women who had ever experienced DV were more likely to have suffered

from anxiety, PTSD, depression, suicide attempts and other mental health outcomes than women who had experienced both child mistreatment (including sexual abuse) and sexual assault and rape in adulthood. DV may exacerbate chronic depression and, evidence suggests, can cause depression; longitudinal studies show that as domestic violence decreases, depression also declines. (68) Studies also show that mental illness increases the vulnerability of women to DV. (71)

It has been suggested that DV may be the single most important cause of female suicidality (72); this may especially be true for migrant women. A Swiss study found that Turkish migrant women who had experienced violence had higher rates of emergency treatments and suicide attempts than non-abused women. (73) This again shows that DVA impacts mental health. Finally, witnessing domestic violence between parents has a harmful impact on the physical and mental health of children. (67)

1.2.3 The financial impact of DVA

An analysis of the relations between domestic violence, health status and the utilisation of the health care system shows an overall deterioration of physical and mental health, more sustained injuries and greater use of the health care system (including prescriptions and hospital admissions), when comparing abused and non-abused women. (74)

One comparison of health plans in the US indicated that women with histories of domestic violence (n=126) generated 92% more costs per year than women with no such histories, with mental health services contributing most to the increased costs. (74) In 2008, in England and Wales, the estimated total direct costs of domestic violence were £16 billion; healthcare alone accounts for £1.73 billion. (75) Additionally, some DVA-related health problems may never present to health services and others may not be attributed to DVA; thus, these figures presumably underestimate the real financial impact of DVA. Even though pain and suffering related to domestic violence are intangible, in England and Wales its cost is estimated to be £9.95 billion, while the indirect costs of lost economic output (e.g. due to time off work due to injuries) account for around £1.92 billion a year. (75) Therefore, it can be concluded that DVA does not only have serious individual health consequences but has also substantial economic implications for society and health services. (6)

1.3 Theoretical background of DVA

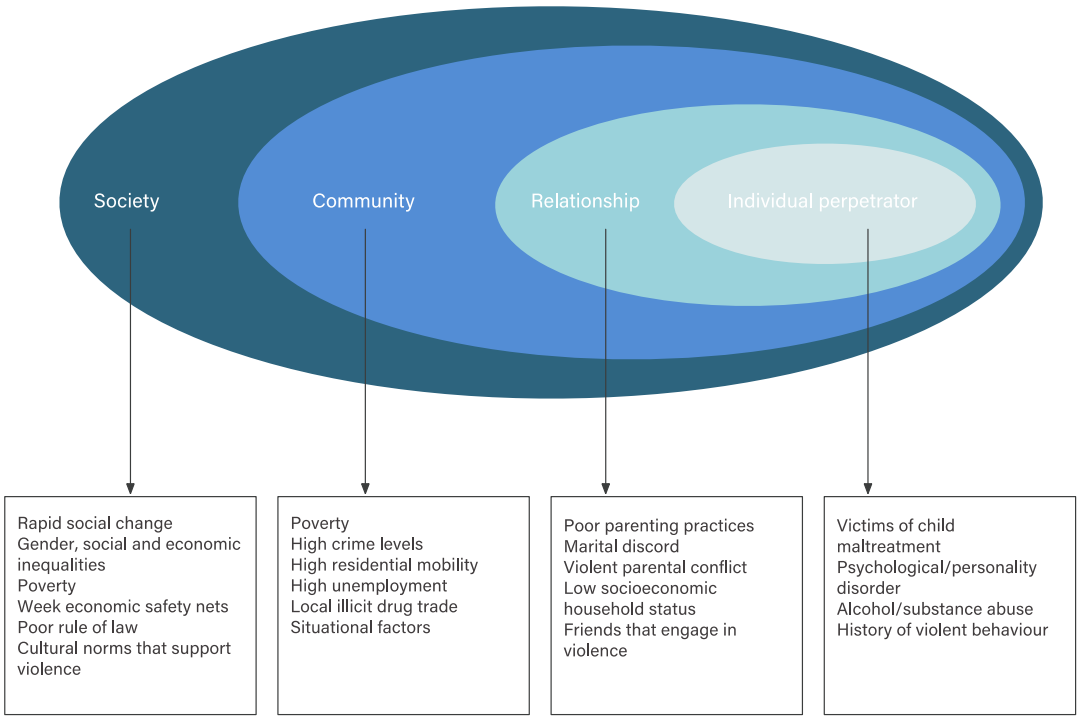
There are various explanations for DVA, although I will only be able to give a succinct overview here. I will also briefly describe the concept of intersectionality. I will then examine how 'culture' is used to explain DVA among migrant women and, in this context, also look at acculturation.

1.3.1 Explanations for DVA

Explanations for DVA either centre on the individual (individualistic approaches), the family (systems approaches) or societal structures (structuralist approaches). (76) The ecological framework is used by the WHO (1, 77) to explain DVA (see Figure 1.2 below) as previously applied by Heise (56) and others. (e.g. (78))[14] Rather than singling out any one factor, this framework looks at multi-level risk factors for DVA. Thus, this ecological framework integrates several explanations regarding DVA and gives equal weight to the interactions of factors between the different levels (e.g. individual or societal) and at the same level (e.g. individual level).

[14] The ecological framework is based on Urie Bronfenbrenner's ecological systems approach of how children grow and change in the context of multiple systems. (79)

Figure 1.2: Ecological framework



Source: Adapted from Heise 1998 (80), Bronfenbrenner (79), WHO (1, 77)

There are four different levels: individual, relationship, community and society. (1) The individual level describes how a person's history (i.e. childhood abuse or witnessing violence between parents, or biological factors, such as psychological or personality disorders and/or alcohol or substance abuse) may influence their behaviour and likelihood of perpetrating or encountering violence. (2) Personal relationships (i.e. with family members, partners and friends) also play an important role as they may determine whether one becomes violent or encounteres violence. (3) The community provides the context in which relationships occur. These include neighbourhoods, workplaces and migrant communities and influence the probability of DVA. For instance, unemployment may increase the risk of DVA. (4) Factors related to society also strongly influence the likelihood of violence by, for instance, promoting and maintaining gender inequality, male dominance over women and cultural values or norms which endorse violence for conflict resolution. (77) I will now examine why migrant women may be more vulnerable to the above.

1.3.2 Intersectionality

The term intersectionality was coined by Kimberlé Crenshaw, a legal scholar of critical race theory and an American civil rights advocate. (81) Crenshaw used the concept to describe the complex oppression and discrimination faced by Afro-American women due to both

their gender and 'race' (82), which are '*greater than the sum of racism and sexism*'. ((82)p. 140).

Crenshaw used antidiscrimination lawsuits of African American women to demonstrate that the dominant conception of discrimination was insufficient as it only looked at subordination occurring on a single categorical axis, either on grounds of gender or 'race', but not both – as it did not allow for 'compound discrimination'. By treating '*race and gender as mutually exclusive categories of experience and analysis*' ((82) p. 139), Afro-Americans' experiences were marginalised and denied. Analysis based on the single-axis framework was found inadequate as it '*erases Black women in the conceptualization, identification and remediation of race and sex discrimination by limiting inquiry to the experiences of otherwise-privileged members of the group*'. ((82) p. 140) Crenshaw showed that Black women were not successful at raising lawsuits of either gender or 'race' discrimination to represent *all* women or *all* black people respectively, as they were *Black women*. Thus, they were either special cases as such and thus did not represent *all* (i.e. white) women, or women and consequently could not represent Black men.

Crenshaw (81) then examined the link between 'structural intersectionality' and 'political intersectionality.' Structural intersectionality refers to a union of '*race, gender, and class domination*'. Social interventions which only address racism, sexism, or poverty separately are '*insufficient to address the needs of a woman of color marginalized by the interaction of all three systems of power*'. Political intersectionality highlighted '*that women of color are situated within at least two subordinated groups that frequently pursue conflicting political agendas*'. ((81) p. 1252)

> *Among the most troubling political consequences of the failure of antiracist and feminist discourses to address the intersections of race and gender is the fact that, to the extent they can forward the interest of "people of color" and "women," respectively, one analysis often implicitly denies the validity of the other. The failure of feminism to interrogate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of antiracism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women. These mutual elisions present a particularly difficult political dilemma of women of color. Adopting either analysis constitutes a denial of a fundamental dimension of our subordination and precludes the development of a political discourse that more fully empowers women of color. ((81) p.1252)*

Here, among other Black feminists, Crenshaw challenged feminism's premise that there was a universal gendered oppression of women. This claim centred on white middle-class women and thus neglected minority women, who were oppressed by other important factors such as 'race', class and sexuality. Conversely, the Afro-American community did not want Afro-American women to raise domestic violence as this would harm anti-racist work by reinforcing negative stereotypes about Afro-American men. (81, 82)

Crenshaw (81) applied her intersectionality framework to migrant women who had experienced DV. She highlighted that these women were discriminated against in US immigration law, since their residency was dependent on their husbands' immigration status. To prevent marriage fraud, migrant women were required to be married for two years before they could apply for independent permanent residency. This led many migrant women to endure violence because of fear of deportation. Although this Act was changed in 1990, and allowed for a waiver when experiencing DV, meeting the requirements by obtaining sufficient evidence (including reports from police and medical staff) was very difficult for migrant, and particularly Black, women. ((81) p.1248) Notably, migrant women's lack of knowledge regarding their legal status was also used by their husbands to threaten them with deportation. [15] Furthermore, Asian migrant women encountered 'cultural barriers' that impeded disclosure, such as living in extended families, lack of privacy or access to a telephone and lack of opportunity to leave the house. This increased migrant women's dependencies on their husbands. Moreover, there were also structural barriers, such as language barriers, which not only limited women's access to information about these services and refuges/shelters, but also access itself as some shelters/refuges turned migrant women away due to lack of bilingual personnel and resources. (81)

Since its initial articulation almost 30 years ago, intersectionality has been widely applied and used by many scholars to mean different things. The focus of intersectionality can be on identities (e.g. black, women), categories of difference (e.g. 'race', gender), differentiation processes (e.g. the production of subjectivities and social differences through racialisation and gendering discourses and practices) or on systems of domination (racism, colonialism, sexism). (83) It is also closely associated with stratification[16]theory, which studies *'differential hierarchical locations of individuals and groupings of people on grids of power'*. (83)

The concept of intersectionality is much discussed within analyses of (a) the relationship between the different axes of power and (b) the number of axes of power that should be considered in each intersectional analysis. (83) While some have exclusively focussed on *'race'* and gender, others consider 14 social divisions (83), depending on the different situations and forms of analysis. While there are some more universal social divisions/categories (e.g. gender, class, race/ethnicity) others (e.g. (un)documented migrants) may also be important. (83) It has, however, been critiqued that the

[15] Although some of these women had already attained permanent residency.
[16] 'The systemic forms of inequality that divide societies and broadly impact occupational and social status.'(84) '*Stratification in sociology is usually applied to studies of structured social inequality; that is, studies of any systematic inequalities between groups of people, which arise as the unintended consequence of social processes and relationships.*' (85)

intersectionality framework has been applied so widely that it has lost its focus on women of colour. (86)

It has also been questioned how intersectionality can be analysed effectively, that is how to attribute importance to factors in a given situation. (83) Here, questions include whether all factors should be given equal or differential weight, and how these factors should be separated. (83) Other questions refer to whether, and in what ways, intersectionality can serve as a theory of method. (83) Another critique of intersectionality is its limit of advancing a contoured understanding of identity (87), yet Crenshaw maintained that it was not a '*new, totalizing theory of identity*.' ((81) p. 1244) Instead, intersectionality can be an analytical tool to study structural power and inequality. (88) It has been questioned whether maintaining Black women's paradigmatic status within intersectionality is essentialist and thus problematic or '*whether attempts to move 'beyond' black women constitute attempts of erasure and displacement*'. (83, 87) In keeping with the latter, Chantler and Thiara (86), among others, recently argued that 'Black women' should remain intersectionality's focus as erasure and submersion of these affects theory, policy and practice – for instance, leading to closure of specific BME (Black and ethnic minority) services as they cannot be accessed by non-BME women.

In this thesis, I use intersectionality as an analytical tool to examine and understand the various mutually reinforcing oppressions faced by migrant women in healthcare and beyond.

1.3.3 Culture and DVA

As I discussed earlier, 'culture' was and still is used as a term when looking at *other* cultures. This is particularly true when it comes to DVA, which is often attributed to the migrant women's cultures. (89) These assumptions may lead to overlooking or excusing DVA in migrant communities for so-called cultural reasons and for fear of being called racist. (90) However,

> *cultural interpretations are made to explain the highly publicised violence involving members of the 'ethnic minorities', while acts of violence experienced by women of western cultures are regarded as individual acts, bearing no relation to a broader system of gender relations, and, above all, no reference to a 'sexist culture' is ever made. ((89) p. 40)*

This reflects a power differential:

> *The powerful are depicted as having no culture, other than the universal culture of "civilization"; in contrast, those without power are singled out and culturally endowed as a means of attributing deviance and maintaining social, economic, and political distance. (Rosaldo, 1993 (91) as cited by Sokoloff and Dupont (92) p. 17)*

Narayan termed this 'death by culture'. (93) Dowry-related murders in India were explained culturally, whereas DVA homicides in the US, although comparable in numbers, were not. Rather than questioning the values and norms of Western culture, Western cultural identity was considered neutral, against which '*the image of static, monolithic and uncivilised 'cultures' [was] projected*'. (89)

Cultural relativism is often misunderstood to only mean one of its dogmatic forms, or moral relativism (94), which rejects universal human rights and undermines women's equality.

> *Recently, cultural relativism has become a straw man term, defined pejoratively as the strongest form of moral relativism; namely, that we cannot make any kind of moral judgments at all regarding foreign cultural practices. At the turn of the 20th century, cultural relativism was a progressive anthropological theory and methodological practice that sought to valorize marginalized communities in an inegalitarian world. Now cultural relativism is criticized as doing precisely the opposite: allowing repressive and inegalitarian societies to hide behind the cloak of cultural difference. (94)*

Yet, originally, cultural relativism was a response to ethnocentrism (the belief that one's culture is superior) and then prevailing '*biological and racial determinism*.' (94, 95) As stated earlier, this assumed that culture develops in a linear fashion from the 'primitive' to the 'savage' to the 'civilized', whereas cultural relativism suggests that cultures develop consistently with the conditions of history. (94) It also proposes that culture, instead of 'race' or biology, primarily shapes social life and human behaviour, as well as the way '*in which members of a particular cultural group think, act, perceive, and evaluate*.' (94)

Research on migrant or ethnic minority women, as also described by Crenshaw earlier, shows that cultural values may restrain migrant women from recognising, disclosing DV and leaving abusive relationships. Crandall's study (96) of so-called Russian mail-brides showed that these women perceived domestic violence as something normal: '*Domestic violence is a normal thing. It is part of destiny, and you have to tolerate it.*' ((96) p. 945) Likewise, the acceptance of patriarchal norms may influence some Asian migrant women's perception and interpretation of what they perceive and define as DV. (97) Shame is a great barrier and often linked to family obligation and so-called 'cultural loyalty'. (54, 90, 98, 99) For instance, the concepts of shame (*Sharam*) and honour (*Izaat*) may force South Asian migrant women to stay in unhappy and violent marriages (e.g. (54, 100)). Some migrant women face being ostracised if they contravene these values (e.g. (54, 101)). Although shame is also a barrier for non-migrant women (e.g. (102)), these barriers are seldom 'culturally' framed. Yet, there are many other migration-specific factors which affect recognition, but also act as barriers – such as immigration status and loss of social network.

> *Too often, structural forces shaping cultural practices are hidden from view. Pervasive structural pressures that deny women economic and political agency include global*

> *inequalities, new articulations of patriarchy found in religious fundamentalisms or orthodoxies, and the legacies of racism and colonialism ((103) p. 15)*

This will be discussed in the following section and later in this chapter.

1.3.4 Acculturation and DVA

Acculturation describes the process by which one's own cultural patterns are adapted to another culture. (104) Some studies argue that the degree of acculturation will affect migrant women's abilities to identify and recognise DV and not, as previously mentioned, perceive it as 'normal' – the husband's right or a family matter not to be discussed with outsiders. (96, 97, 105-107) Acculturated migrants seem to identify domestic violence better than less acculturated migrants. (108) Similarly, Barata and colleagues (106) noted a generation gap in Portuguese migrants in Canada: second-generation migrants were more inclined to name domestic violence, whereas first-generation Portuguese women identified it less frequently and were more likely to tolerate it. However, studies often use different definitions and classifications, or proxies, as indicators for acculturation – such as English proficiency and language spoken at home.

There are various definitions of acculturation. One of the first described acculturation as the result of continuous first-hand interactions between groups of individuals from different cultures, whereby changes could occur in either or both groups. ((109) p. 149) In the context of health, acculturation may be defined as the:

> *process of learning and incorporating the values, beliefs, language, customs and mannerisms of the new country. (110)*

This process may affect health behaviour, such as diet, and help-seeking behaviour. Marmot (111) showed that the risk for heart disease was lower among first generation Japanese migrants due to their diet[17]; yet this risk became more similar the more accultured migrants and their descendants became. Acculturation is thought to influence the expression of health problems (e.g. somatising), healthcare expectations and help-seeking behaviour. (111) However, migration is not thought to have a negative effect *per se*, instead it can be both positive (due to improved healthcare access or escaping violence) and negative (e.g. racism or being more vulnerable to DVA).

[17] There is also a healthy migrant effect, whereby individuals who migrate are significantly healthier when compared to both the host society and people from their country who remain to stay. This can partly be explained by pre-selection processes.

1.3.4.1 Acculturation outcomes

Berry (104) proposes four possible acculturation outcomes of an interaction between the individual migrant and the host society to a varying degree (see Table 1.2 below): 1) assimilation, 2) integration, 3) separation and 4) marginalisation.

Table 1.2: Acculturation outcomes

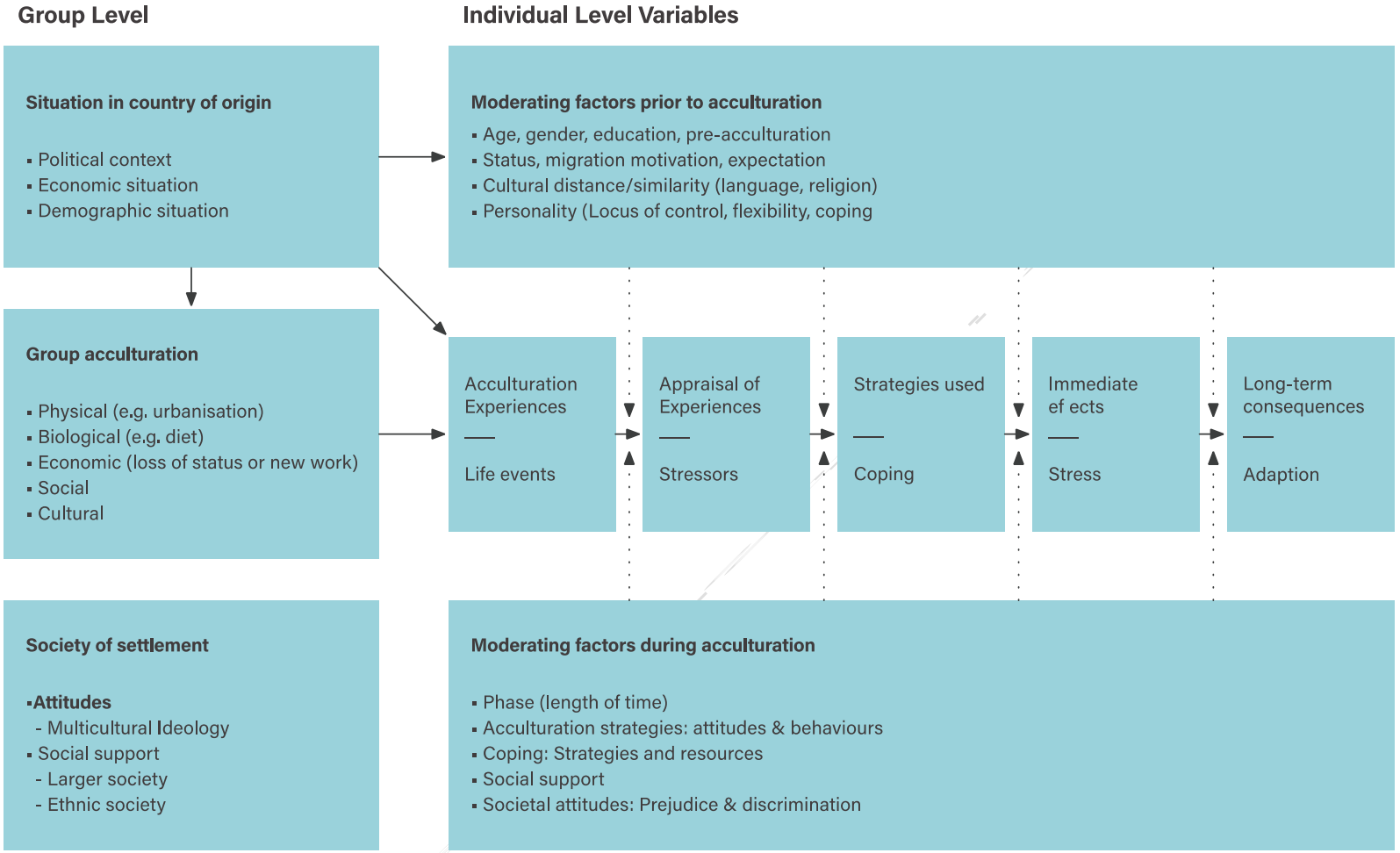
Maintenance of culture of origin		Cultural adaption	
		Low	High
	High	Separation	Integration
	Low	Marginalisation	Assimilation

Source: Adapted from Berry (104)

Assimilation is characterised by a complete adaptation to the culture of migration. Separation describes the preservation of one's culture with only few changes. (104) Integration is achieved when the values of the country of origin are maintained, yet the person also participates in the activities of the culture of migration. Marginalisation, on the other hand, is characterised by the process of an individual becoming disconnected from both his/her culture of origin and the culture of migration. (104)

Berry and Kim (1988) (112) suggested that the acculturation process can cause increased 'acculturative' stress, which is mediated by the recency of arrival, the receptiveness of the host society, the degree of similarity between culture/country of origin and the culture of immigration (e.g. regarding language and customs), demographic factors (e.g. age, gender, education and occupation) and the degree of religiosity of migrants. (112) Both separation and marginalisation represent negative outcomes impacting the health of migrants. Their model is illustrated below in Figure 1.3

Figure 1.3: A framework for acculturative research



Source: Adapted from Berry ((104) p. 15)

Berry's 2x2 matrix has been criticised for classifying migrants into four broad categories. (113, 114) The validity of the marginalisation category has been particularly criticised. (113) The model has been viewed as over-simplistic in proposing a 'one size fits all' approach and failing to consider migration type (voluntary vs forced migration), ethnicity and cultural similarity. (113) However, recent research has found some degree of validity for the acculturation model (115), although using clustering methods have shown the validity and reliability of the marginalisation category to be small or non-existant in contrast to the other three acculturation outcomes. (116, 117) Berry proposed that this would only apply '*to a small segment of migrants who reject (or feel rejected) by both their heritage and receiving culture*.' ((115) p. 4) However, it has been argued that relying only on cultural and acculturation explanations for migrants' health conceals the impact of structural factors; moreover, that studies on the health of migrants should include intersectionality theory. (118)

1.3.4.2 Migration and health

Three factors are shown to influence the health status of migrants:

1) The conditions in their home country prior to migration; for instance, violence, war, nutrition/food (119) and the experience of violence during the flight/escape. (45, 119)
2) The conditions during the migration process, such as stress, separation from family (119, 120), structural violence[18] and other violence experienced while, for instance, applying for asylum. (8)
3) The prevailing conditions in the country of migration, both in the short term (e.g. immediately after arrival) and the long term such as feelings of alienation, family separation, language and communication problems, different culture, poorer working, living and educational conditions (119), residency status (24, 121, 122), xenophobia and ongoing structural discrimination. (120)

In healthcare, identifying and managing illnesses in migrants and ethnic minorities can be challenging due to language and cultural barriers. (120, 123, 124) The problem of under-diagnosis is more pronounced in the migrant population due to a) communication barriers when assessing or diagnosing migrants, b) lack of intercultural competence on the part of health professionals and c) poor knowledge of the psychological factors underlying health and illness in migrants. (120, 125, 126) The emotional suffering of migrants may be

[18] Structural violence describes unequal power and ownership relations causing unequal opportunities to participate in social life (Galtung 1975).

expressed differently due to lack of fluency in the dominant language and a different cultural understanding of health and illness. (127) This, in turn, may lead to misdiagnosis and inadequate treatment. (128) Further obstacles to accessing healthcare may be lack of immigration status and lack of health insurance (81, 129), the healthcare sector being different from the country of origin (130) and distrust of and concern about these institutions, in both their country of origin and migration, due to negative past experiences. (131)

1.4 Help-seeking for DVA

In this thesis, I examine the healthcare experiences of migrant women affected by DVA, including help-seeking behaviour. Having provided a definition of help-seeking earlier (see 1.1.4);[19] I will give a brief overview of a help-seeking framework applied to DVA. Reports of migrant women's help-seeking experiences in healthcare will be presented in my synthesis and interview findings chapters (see Chapters 3 and 5, respectively).

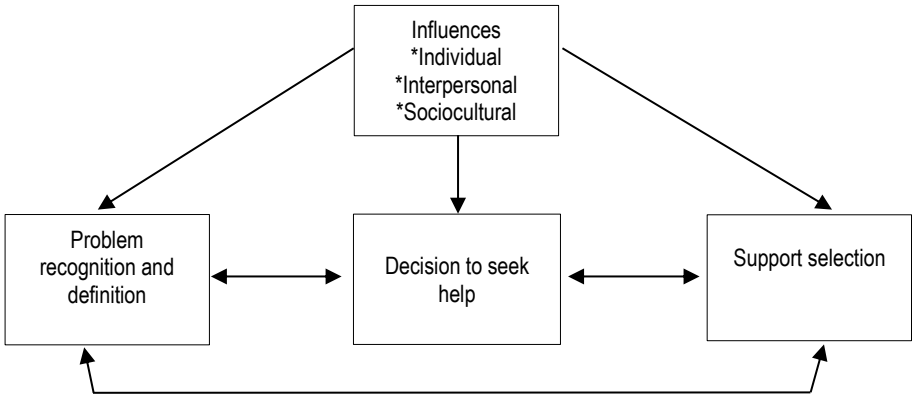
1.4.1 Help-seeking models used for DVA

Models, or theories, of help-seeking have been used to understand the help-seeking behaviour in women with histories of DVA. (126) I will briefly outline one relevant framework.

The model of help-seeking and change put forward by Liang and colleagues (126) attempts to understand women's help-seeking behaviour, partly drawing on theories applied to DVA – such as the stages of change transtheoretical model of change (TTMC). (132) Liang and colleagues (126) applied help-seeking theories to 'stigmatising' situations to develop a conceptual framework for DVA. They discerned three relevant cognitive processes, or stages, of seeking help: 1) defining the problem, 2) deciding to seek help and 3) selecting a source of support. Each of these stages are influenced by individual, interpersonal and socio-cultural factors, which also encompass economic, political and cultural contexts; all of these determine the decision-making. (126) (see Figure 1.4 below) Liang and colleagues emphasise that the internal cognitive processes, although often characterised as distinct stages, are not linear. The authors propose that how a woman appraises her situation will influence what kind of help she seeks; however, the person she discloses her situation to will also influence how she defines the problem and any further help-seeking. (126)

[19] Help-seeking and help-seeking behaviour will be used interchangeably.

Figure 1.4: A model of help-seeking and change



Source: Based on Liang and colleagues p. 73 (126)

According to Liang and colleagues, the way women define their problem affects their help-seeking, which they relate to two internal conditions from the help-seeking literature (133): problem recognition and recognition that the problem cannot be resolved alone and requires external help. However, the woman's relating style – that is whether she approaches the helper openly or cautiously – also impacts the help-seeking. (126)

Previous studies were used by Liang and colleagues to show the suitability of the above framework alongside using vignettes to illustrate its applicability. To my knowledge, their framework has not been evaluated. This framework partly addresses and overcomes the shortcomings of psychological models, which have often been critiqued for neglecting the role of social interaction, the situatedness of behaviour, and the broader context. Moreover, while acknowledging the importance of the interpersonal interaction and the role of the helper, the framework has not been specifically applied to healthcare. The interaction in healthcare is particularly vital as it shapes health outcomes.

The transtheoretical model of change (TTCM) by Prochaska and DiClemente (132), which Liang and colleagues partly build on, consists of a series of stages from pre-contemplation via contemplation to action (i.e. leaving) and maintaining safety. (134, 135) Originally developed to explain engagement with substance abuse treatment, this model has been applied to DVA research. However, while it has been found useful when applied to the counselling setting (134), it has limitations when applied to DVA: the stages of change assume a linear process although this process seems to be non-linear; the perpetrator(s) limit(s) a woman's freedom to seek help and women, in turn, may use various pathways to improve their safety. (135)

Thus, alongside varying degrees of considering or neglecting contextual factors, psychological theories of help-seeking often emphasise women's cognitions involved in

making the decision to seek help (i.e. recognition that there is a problem and that this problem requires outside help. (126) However, as stated earlier, not all migrant (and non-migrant) women are aware that they are experiencing DVA, nor do they realise its impact on their own and their children's physical and mental health. Women's recognition of DVA may also come only retrospectively after getting into contact with DVA agencies and becoming aware of the label – before then, they may not realise they are experiencing DVA due to shame and self-blame. (135)

1.4.2 Help-seeking of migrant women and barriers

Migrant women seek help for DVA. For instance, Turkish migrant women in Germany were not found to be 'passive' or 'accepting of violence', but instead actively sought help and made use of available services, which did not exist in Turkey. (101) However, the cited study consisted only of women who were recruited through agencies and, therefore, had already sought help. An Italian study found that migrants were seeking help from anti-violence centres more often and at an earlier stage compared to Italian women; they also more frequently pressed charges against perpetrators. (136) The authors related this a) to their sample containing a great number of Eastern European women who were found to have a high level of education and b) the demand from the social services and police to press charges in order to obtain financial help and a place to stay. Other options may be open to non-migrant women (e.g. financial means or staying with family or friends). The severity of abuse may also make these women more likely to seek help and report crime. (136)

Mental healthcare or self-help groups are less often sought by migrant women, even though these women experience more severe violence and, consequently, sustain greater injuries compared to non-migrant women. (44, 45, 136) While migrant women seek help for their injuries, they seldom do for their psychological health. (45) Despite this, or perhaps consequently, they show greater prevalence of depression, suicide and self-harm when compared with non-migrant women. (123, 136) This suggests that many migrant women may not have dealt with the psychological impact of DVA, which may substantially impede their (full) recovery. Not seeking psychological help may be explained by migrant women either not being aware of the available mental health services (45) or feeling reluctant to do due to stigma. (137)

Shamita Das Dasgupta (138), a South Asian scholar, maintains that migration increases women's vulnerability to DVA due to their often-dependent immigration status '*and the role that anti-immigrant sentiment plays in law, policy, and service provision*.' ((138) p. 58) There are several barriers to help-seeking, namely poor knowledge of women's legal

rights and available help in the country of migration. (47, 100, 101, 139) In a German study, awareness of support services was found to be lowest in i) older migrant women ii) migrant women whose educational status was lowest and iii) migrant women whose duration of stay in Germany was shortest. (44) Also, legal rights and supportive institutions may differ from those in the countries of origin and migrant women may, therefore, generally distrust such institutions. (140)

Dasgupta (138) uses three categories of barriers which South Asian migrant women affected by DVA may encounter based on her previous research (99, 138): personal, institutional and related to cultural ideology. Although classified differently by other researchers regarding their overarching categories, they mostly refer to the same categories. I have summarised and slightly adapted Dasgupta's (138) categories in the table (Table 1.3) below.

Table 1.3: Barriers to help-seeking

Personal • Shame is a major barrier which includes losing face and bringing disrespect to the natal and wider family but also to the wider community • Fear of separation and retaliation closely related to this safety • Lack of financial resources due to migration and dependency on the abuser • Lack of social support due to migration which may increase dependency on the perpetrator • Dearth of survival skills that is lack of basic skills to survive in the country of residence such as how to use public transportation, banks, or find a job
Institutional • Immigration and public benefit policies restrict migrant women's ability to leave and access resources because of their often-dependent immigration status on the abuser • Cultural insensitivity of organisations • Financial requirements to seek legal help, escape and set up a new household due to being dependent on the abuser • Child custody issues are exacerbated because of women's lack of residency/immigrations status. Separation/divorce may lead to deportation of migrant women while their children may have residency through birth • Language barriers are a major impediment to communication
Cultural ideology* • Meaning of marriage to self and others. Marriage is meant to be permanent in many religions and divorce is perceived as unacceptable and shameful. This leads women to remain in abusive marriages to keep the family intact particularly for the sake of their children as there is a strong belief that children can only brought up well in an intact family • Acceptability of 'fate'. Some cultures suppose a predestination of life events and thus a violent relationship might be perceived as being caused by previous misdeeds and are thus accepted as 'fate' • Tolerance towards abuser due to cultural gender roles, which emphasise tolerance and compassion and beliefs that 'a good woman can change a man' which may interfere with separation and divorce

Source: Taken and adapted from Dasgupta ((138) p.65-66)

*I have merged themes of this category under the theme meaning of marriage to self and others as, in my opinion, Dasgupta's themes could be subsumed here as they were referring to the same theme. I have also slightly changed and added themes.

Racial[1] or ethnic discrimination and stereotyping is a major barrier to seeking and receiving help. (90) In the US, stigmatisation and discrimination also seem to be particularly prominent themes for Arab and Muslim migrant women in the aftermath of 9/11, which triggered an anti-Arab political climate in the United States, consequently deterring Arab migrant women from seeking help. (141) These women may not want to conform to stereotypes held by society, and therefore did not reveal the violence they experienced. (90)

African-Caribbean women in Britain are often 'racially' constructed as being '*strong*', '*hard, and feisty*' who can cope on their own and do not need help. (142) The label of a '*passive, vulnerable victim*', which seems '*fitting*' for other migrant or ethnic minority women, is not applied here. However, the 'reverse' stereotype and discrimination (e.g. being seen as a '*passive and helpless victim*') may equally deter women from seeking help. (101)

In a study by Burman, Smailes and Chantler (2004) (90), an Irish woman discussed her experience in the UK, in which instance language was *not* a barrier; although preconceived stereotypes and prejudices prevented her from receiving help.

> *People don't want to see the domestic violence, they know it's going on, they know it's there. Also the fact that I'm Irish. They didn't want to see it when they didn't want to. They do that with domestic violence, if you're from a minority group they do it even more… That invisibility makes you feel like nothing. That may be something that's common with other women, not being seen, it's as though you're nothing. That and the additional abuse, your crime is to come from a minority group, with all its preconceived ideas and prejudices about you, the double hurt prevents you from accessing services, because you know what people think about you, or you know what some of the myths are because you've grown up with them. ((90) p. 338)*

1.4.3 Identification of DVA in healthcare

DVA represents '*a common, hidden and under-researched problem in general practice*'. (2) Seeking help is one part, finding help is another. There are numerous barriers to seeking help which apply to informal (e.g. family and friends) and formal sources (e.g. healthcare professionals (HCPs), police). Two systematic qualitative syntheses (143, 144) shed light on how abused women perceive and experience healthcare responses. I will briefly summarise women's barriers, HCPs' and healthcare system barriers, as well as facilitators, here.

Feelings about abuse, such as shame, embarrassment, fear, self-blame, loneliness, humiliation and denial are frequently stated obstacles to communication among women experiencing DV. (143) Fear and shame are particularly prominent barriers which may cause women to remain silent or deny abuse when asked. Fear on the part of the women may be related to a) the abuser, b) imagined repercussions when disclosing abuse and the consequences for the children or c) being judged, not believed or that disclosure would not

be treated confidentially. (143) Barriers also include accompanying husbands or children being present. (143)

The literature indicates several barriers to communication about DVA from the HCPs' perspective. Asking about domestic violence has been likened by clinicians to '*opening Pandora's Box*', as they feel uncomfortable, powerless and ineffective to intervene and also fear offending women. (145) Many clinicians have not received training on dealing with domestic violence, making it harder to broach the subject. (146) This may be even more of an issue for migrant women, as HCPs may be afraid to offend the women (145) or of being perceived as racist. (90) Due to this, HCPs may choose to instead focus on the symptoms, such as injuries, in women without identifying or acknowledging the primary cause.

HCPs may feel frustrated and helpless if their inquiry about or screening for DV is not successful because of a lack of direct disclosure, which can lead to 'burnout'. (147) This might be especially the case if HCPs strongly suspect that a woman is affected by domestic violence but does not want to admit this, denies it or discloses it but does not leave the perpetrator. (147) In some studies, HCPs were found to be uninterested and did not enjoy providing care for women afflicted by DV because they find it frustrating, dull and the reimbursement for it insufficient. (148) Previous studies also suggested that women's experiences are shaped by inappropriate care, such as feeling rushed or pressure to disclose. (143, 144)

The setting of disclosure might be of relevance. Liebschutz and colleagues (149) concluded that disclosures in the emergency department (ED) are more unhelpful when, compared with, for instance, the primary care setting. In the latter setting, disclosures have been judged to be helpful, although lack of continuity of care (e.g. through rotation of the HCPs) may be an obstacle. (150) Although the ED is often sought for the inflicted injuries. (8, 150, 151), few women reported having been asked about violence. (144) Overall, disclosure was not found to be beneficial *per se*, as unhelpful disclosure leads to emotional distress and alienation from healthcare. (149) Finally, stereotyping and a lack of understanding of DV in ethnic minority cultures was found to be a barrier for HCPs when communicating with ethnic minority women. (90, 137, 144, 152)

Communication between health care professionals and migrant women affected by DV was of key importance: women appreciated being asked (in a sensitive manner) about DVA if presenting symptoms. Yet it was not always clear whether women preferred direct or indirect questioning, and this appeared to be dependent on the situation. (143) Women responded positively to HCPs:

- who listened to them non-judgementally, were kind and empathic, respected their autonomy and involved them in any decision-making,
- who gave practical support or referral to specialist services,
- who knew about resources available and were aware of the complex and often long-term nature of domestic violence, impacting both their social situation and psychological being (which had no 'quick fix' (143))

DV training of healthcare staff and introducing multidisciplinary approaches within primary care (153) and the ED (154) with dedicated staff onsite or on reach have improved this.

1.5 Overview of PhD thesis

My PhD thesis consists of six chapters. In this first chapter, I have provided definitions for significant terms and an overall introduction. In the second chapter, I will describe my methods for the systematic review and qualitative synthesis. My synthesis findings will be presented in the third chapter. My fourth chapter will describe the methods used for the interviews with migrant women and professionals. The interview findings will be presented in my fifth chapter. In my sixth chapter, I will summarise my synthesis and interview findings and then discuss them in the context of available literature. Here, I will also discuss my conceptual insights based on the findings of both studies. Finally, I will look at implications of this work for theory, practice and policy and make appropriate recommendations.

1.6 Chapter Summary

In this chapter, I have provided an outline of the thesis and its aims, definitions of relevant terms and given a brief background of DVA. Definitions regarding DVA, migrants and culture are not clear-cut, and these definitions affect what kinds of data are generated (e.g. how migrant women are classified and what kind of forms of DVA are studied) and whether data are comparable. The ecological theory encompasses many partial explanations for DVA. The concept of intersectionality highlights multiple oppressions based on, for instance, gender and 'race'. Cultural explanations are only used to explain DVA among migrant women. Acculturation seems to impact health, recognition of DVA and health behaviour and help-seeking. Help-seeking of migrant women, in turn, seems constrained by individual, socio-political and socio-cultural factors. DVA is often hidden and silenced in healthcare.

Chapter 2: **Systematic qualitative review methods**

2.1. Aim of chapter

The aim of this chapter is to describe and discuss the methods used for my systematic qualitative review examining the healthcare experiences of migrant women affected by DVA. This consisted of conducting (1) a systematic review, (2) a synthesis of the qualitative studies using elements of meta-ethnography, as proposed by Noblit and Hare (1988, (155)) and adapted by others (143, 156-161), and (3) a quality appraisal.

2.2 Introduction: Rationale, aim and objectives

While there is a large body of literature on DVA against women in many different disciplines, there is much less research on DVA against migrant women (30, 162), particularly in relation to their healthcare. Few narrative[20] or systematic literature reviews exist on this topic. (30, 162, 163) Where reviews exist, they often concentrate on a single migrant group; for instance, Hispanic, Latina[21] or Asian[22] women (30, 162, 164) and do not investigate the women's individual healthcare experiences, instead focusing on general barriers to help-seeking. (164, 165) To date, there is no synthesis of the qualitative evidence on the healthcare experiences and needs of diverse migrant women affected by DVA. Consequently, this poses a risk of knowledge fragmentation among experts (i.e. that the results are available for one discipline only (166) and that individual primary studies face the risk of being lost. (161, 167)

This systematic qualitative review sought to address this gap by articulating the healthcare experiences and needs of migrant women with histories of DVA. Within this overall aim, my objectives were to identify and synthesise qualitative evidence:

1) To identify the healthcare experiences of migrant women with histories of DVA
2) To identify how migrant women found support following exposure to DVA

[20] Narrative reviews describe a critical analysis of a topic from a theoretical and contextual perspective. In contrast to systematic reviews, narrative reviews do not follow and report rigorous search and methodological approaches to conduct and evaluate reviewed articles. http://www.scielo.br/scielo.php?pid=S0103-21002007000200001&script=sci_arttext&tlng=en

[21] The 'ethnic' categories of Hispanic and Latina are controversial as they refer to a very heterogeneous group – thus, this requires caution when generalising findings (Kelly 2009). In the US census data, the term Hispanic is used, while Latina refers to self-identifying term depicting a woman who comes from a Latin American country, comprising Mexico, Central and South America and the Caribbean. Both terms are used in this thesis.

[22] Likewise, Asian is a very imprecise 'ethnic' category – it is even broader than the Hispanic term, as in the US official context it comprises '*countries east of Istanbul in Turkey through to Japan*', thus referring to about 50% of the world's population (19).

3) To identify unmet support needs of migrant women with histories of DVA.

My review searched for qualitative literature based on studies which sought '*to interpret, illuminate, illustrate and explore meaning, context, unanticipated phenomena, processes, opinions, attitudes, actions, and to learn about people who are few or hard to reach*'. ((168) p.12-13) I wanted to examine different migrant groups to conceptualise how migration-specific factors may impact their healthcare experience. By doing so, I do not deny the heterogeneity of migrant women. Instead, I aimed to discover commonalities and differences in their experiences to advance theorising across different migrant groups (30) and to inform policy and practice by making, for example, recommendations for suitable generic or tailored interventions.

2.2.1 Synthesis definition

A synthesis can be defined as a '*combination of components or elements to form a connected whole*.' (169) The synthesis depends on the data (i.e. the nature of the primary studies) and the question it attempts to answer. The value of synthesising evidence has been increasingly recognised within a range of disciplines, accompanied by ongoing methodological developments. (170) Qualitative syntheses attempt '*at varying levels, to draw out and integrate findings across qualitative studies in ways that generate new insights and understandings*' ((171) p. 20), whereby the sum is greater than its parts. (155) This is important as the explosion of qualitative empirical studies has led to a build-up of a substantial body of qualitative health research. (171) Qualitative syntheses may lead to theory development or new conceptual insights; they offer added value for researchers, clinicians and policy makers as they give an integrated summary of the evidence relating to an issue, rather than relying only on single studies. (166, 168, 170)

2.2.2 Synthesis approaches

There are various approaches to qualitative synthesis (159), such as meta-ethnography developed by Noblit and Hare (155) and adapted by others (143, 156-161), meta-summary (172), meta-narrative (173), critical interpretive synthesis (174), thematic synthesis (175), framework approach (176, 177) and meta-study. (178) Some synthesis approaches draw upon one or more approaches used in primary qualitative research, such as grounded theory (179) or thematic analysis. (180)

Qualitative syntheses can be broadly divided into aggregative, interpretive or integrative approaches. (181) Aggregative syntheses pool frequencies of themes across qualitative studies. They tend to be 'additive' and are often more deductive, requiring concepts to be clearly pre-defined. Some are aimed at testing hypotheses. (181) Interpretive approaches,

such as meta-ethnography, aim to generate new insights through reinterpretation of the qualitative data across primary studies and are usually inductive, seeking conceptual development. (168) Integrative methods, such as framework synthesis (176), incorporate both deduction and induction and focus on developing an integrated thematic interpretation of an event, phenomenon or experience. (168, 181) Notably, even an integrative synthesis consists of interpretation and plays an important function in theory development. (181, 182) For this reason, there is some overlap between different approaches which can make it hard to discern between them. (181) The selection of a synthesis approach depends on the purpose of the synthesis. My synthesis was interpretive and based on elements of a meta-ethnography as developed by Noblit and Hare. (155)

Qualitative synthesis approaches vary with regard to the detail of how the synthesis is designed and conducted, that is: the extent and stages of iteration concerning the research question (e.g. predefined vs iteratively derived); the search for and selection of studies (e.g. iterative, which mirrors purposeful sampling in qualitative research, vs comprehensive search); the nature of included studies (e.g. qualitative only vs quantitative and qualitative studies; homogenous vs diverse study design, e.g. ethnographies only or qualitative studies of any design); and approach to quality assessment. (183)

Noblit and Hare's meta-ethnography (155) was originally developed to synthesise five different ethnographic studies on desegregation in American schools. When Noblit and Hare first attempted to do this, they followed a more aggregative approach, the outcome of which was that it '*stripped these studies of their interpretive merit and worth*'. (Lincoln and Guba 1980 (184), as cited by Noblit and Hare 1988, p. 17 (155)) This experience led Noblit and Hare to conclude that, for synthesising ethnographic accounts, an interpretive approach was needed. They, therefore, chose to use the interpretations of the authors of the primary studies as data (i.e. the authors' metaphors, themes, constructs and concepts) and to translate '*qualitative studies into each other to achieve new interpretations or conceptual insights*' (155), which will be explained later.

Quality appraisal in qualitative syntheses is a contested issue (185) and, if conducted, the *how* is debated. Some researchers use the studies' *relevance* as the primary inclusion criterion. (185) From this perspective, a study should be included in a synthesis if it is relevant to the research question and is judged to contribute to conceptual or theory development in the field of study. Here, the methodological reporting quality of a study is judged to be an insufficient basis for inclusion in a synthesis, as quality appraisal tools are viewed as limited in their capacity to determine the 'quality' of a study. Barbour, for example, argues that a rigid and mechanistic adherence to checklists or other mechanisms

does not ensure quality and is of debatable value. (158, 185) For instance, a well-written and relevant paper may not report the methods in detail due to the journal's word limitation.

While recognising these wider debates as to whether and how qualitative studies should be critically appraised, I chose to include a judgement of the quality of studies within my synthesis process. This was done to enhance transparency and rigour in the reporting of my qualitative synthesis. I did not use quality appraisal as a means of excluding studies, but rather sought to report the quality of relevant studies in a 'sensitivity analysis' so that readers can make a judgement about the contribution of 'weaker' and 'stronger' papers to the synthesis. Tong and colleagues (170) have proposed guidance, termed enhancing transparency in reporting the synthesis of qualitative research (ENTREQ), which I sought to adhere to and will outline in detail later (see 2.3.1 and 2.3.3).

2.3 Methods

I will now describe my methods, starting with the systematic literature search.

A systematic review can be defined as an assessment of evidence, which has been undertaken to answer an explicitly stated question. (168) It uses clearly stated methods '*to identify, select and critically appraise primary research*.' ((168) p. 181) I critically appraised the quality of the included studies using an appraisal instrument called Critical Appraisal Skills Programme (CASP). (186) As noted previously, the results of this appraisal were not used to exclude studies, but rather to perform a sensitivity analysis, which I will report later. Third, for my analysis, I used an interpretive and inductive way of extracting, analysing and synthesising data from papers using the elements of the meta-ethnographic approach, as originally proposed by Noblit and Hare (1988) and adapted by others. (143, 156-161)

2.3.1 Systematic literature review

I followed ENTREQ guidance (170) and searched systematically for studies. As outlined earlier, my overall aim was to examine the healthcare experiences and needs of migrant women affected by DVA. To adhere to best practice, I published the protocol for the systematic review on PROSPERO (see Appendix 1), which represents an international database where one can prospectively register systematic reviews in health and social care ((187); see Appendix 1 for PROSPERO protocol[23]). This was done to minimise the risk of

[23] http://www.crd.york.ac.uk/PROSPERO/display_record.php?RecordID=8718&VersionID=12779

duplication, to allow me to keep a check on my review process and the original plan, as well as to make my methods transparent.

2.3.1.1 Databases used

The following databases were searched: MEDLINE (Medical Literature Analysis and Retrieval System Online), CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO, EMBASE (Excerpta Medica Database), PubMed and Web of Science. The databases were chosen as they focus on health and the Web of Science as it comprises a wide range of interdisciplinary research, as well as conference proceedings. In addition to PubMed, Medline was chosen as it also contains in-process citations indexed with PubMed. The search was complemented by hand searches of key journals, writing to first authors of key papers and examining reference lists. All databases were searched from inception to February 2014 and EndNote (187) was used to manage references. In May 2018, I updated the search of all databases to cover the period from February 2014 until May 2018.

Although my database search strategy identified theses and reports, I additionally searched the following sites for grey literature: OpenSigle (System for Information on Grey Literature in Europe), EThOS (Electronic Theses Online Service) and DART (Digital Archive of Research Theses). I first searched for synonyms of DV to determine whether they would yield any results. Next, I did this for the other concepts in this thesis (migrants and healthcare). However, since these sites contain only simple search engines and cannot run the same complex searches as outlined above, the searches were often limited to five search terms. I decided to combine these and search only the DV terms used by all the three grey sites. In a second step, I manually searched through the results for migrants and healthcare. Often, only the title was available, and I also had to add abstracts manually into EndNote.

2.3.1.2 Search terms used

I enlisted the help of a subject librarian in defining the search terms and conduct an appropriate search strategy. The term ‘migrants’, for instance, was exploded using the MeSH (Medical Subject Headings) tree or the various databases’ thesauruses.

The systematic search strategy had three main concepts: DVA, migrant women and healthcare. Since there is no universal definition/operalisation for either DVA or for migrant women, a combination of MeSH terms such as ‘Domestic violence’ and ‘Transients and Migrants’ and other databases’ equivalent headings, as well as alternative synonyms,

phrases and text word searches (see Table 2.1) were used employing the Boolean operators (e.g. OR/AND). I did not use any filters or terms to identify qualitative studies; this is problematic as the term 'qualitative' is not clear-cut (188) and not all databases index it adequately. (189) This resulted in identifying both quantitative and qualitative studies.

Table 2.1: Terms for literature search (abridged overview)

Construct	Search terms/alternative terms/synonyms
Domestic violence	Domestic Violence or Spouse Abuse or Battered Women or Battered Females or Partner Violence or Intimate Partner Violence or Family Violence
Migrant	Immigration or Migration or Human migration or "Emigrants and Immigrants" or Migrant farm workers or "Transients and Migrants or Refugee or Migrant worker or migrant* or immigrant* or emigrant* or refugee* or asylum seek* or foreigner* or country of birth or foreign born or Ethnic groups or ethnic* or Minority groups or minorit* or ethnically diverse or ethnic minorit* or foreign or non-native or black minority ethnic or newcomer* or new-comer* or alien* or adoptive citizen* or incomer* or naturali#ed citizen* or temporary foreign worker* or Vulnerable populations or vulnerable population*
Healthcare	Health Care or Healthcare or Health Service* or Primary Health Care or Primary Healthcare or Primary Care or Secondary care or secondary healthcare or secondary health care or Tertiary care or tertiary healthcare or tertiary health care or General Practice* or Medical care or Family health care or Family healthcare or Family practice* or Primary Care Nursing or Community Health Nursing or Nursing or Dental facilit* or Preventive Health Service

Where possible, I performed adjunct searches. The search strategies for the electronic databases can be found in Appendix 2. It should be noted that when developing an adequate search strategy, it has to be sensitive (i.e. able to find *all* the records of interest by being inclusive) yet precise[24] (i.e. to only identify relevant records of interest). (190)

2.3.1.3 Types of studies included

I only included qualitative studies that had illustrative free text data from participants (i.e. verbatim quotes). For this, I used my decision-aid flowchart (explained later and shown in Figure 2.1 below). The inclusion criteria were empirical qualitative studies (stand-alone or discrete components of mixed method studies), which a) employed qualitative methods for the data collection and analysis, b) included migrant women with histories of DVA, c) reported their experiences and needs regarding DVA within healthcare, and d) had

[24] While in medical testing the term 'specificity' is used, information science calls this 'precision'.

undergone some level of peer review (such as journal papers, book chapters and dissertations).

The qualitative methods used comprised interviews, focus groups and observations. There were no language or date restrictions.

2.3.1.4 Participants

My population of interest was migrant women aged 16 years or older, who had been exposed to DVA (i.e. life-time abuse). As explained earlier[25], I defined DVA as emotional, physical, sexual abuse or coercive control carried out by a male husband/partner or extended family members, based on the definition by the UK government. In my searches, I excluded same-sex relationships; I specifically wanted to examine male-to-female violence as it is different in terms of both its frequency and severity (e.g. sustained injuries). (191) However, by doing so, I do not deny the existence of same-sex relationship violence. Indeed, I included female-to-female violence from extended family members (e.g. mother-in-law) (151), if this appeared in the publications.

For inclusion, studies could include migrant women as the main population of interest or as a subset, yet the findings for migrant women had to be identifiable in that they were presented and discussed separately. I defined migrant women as women who:

> *were foreign-born (e.g. outside the UK); b) to, for instance, non-British (foreign-born, e.g. no British citizenship/nationals) parents and c) had come to live, for instance, in the UK for various reasons (this could include asylum seekers and refugees).*

To allow for comparison between and across countries (for example, not to compare Asian migrant women in the UK with Somalian migrant women in Kenya), I restricted the inclusion to studies based in high-income OECD (Organisation of Economic and Cooperation and Development) countries. My rationale for this was that these countries were similar in terms of income, gender equality and development, and legislation against gender-based violence (e.g. laws against marital rape[26]). For this, I consulted several other classifications; these included the United Nations Department of Economic and Social Affairs (UN DESA), as cited by the 2013 World Migration Report (WMR) (192), the World Bank's classification, based on the gross national income (GNI) per capita, and the United Nations Development Programme, using the Human Development Index (HDI) as cited by

[25] '*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual, financial, emotional.*'

[26] It should be noted that many of the high OECD countries, including Finland and Germany, criminalised marital rape relatively recently (in 1994 and 1997, respectively).

the WMR 2010. (193) The countries included in these classifications were wide-ranging. For instance, Saudi Arabia, which was included in the World Bank classification, may be wealthy (at least for a part of the population), yet in terms of women's rights, it still very restricted and unequal.

High income OECD countries comprise the following: (1) Australia, (2) Austria, (3) Belgium, (4) Canada, (5) Chile, (6) Czech Republic, (7) Denmark, (8) Estonia, (9) Finland, (10) France, (11) Germany, (12) Greece, (13) Iceland, (14) Ireland, (15) Israel, (16) Italy, (17) Japan, (18) Korea, Rep., (19) Luxembourg, (20) Netherlands, (21) New Zealand, (22) Norway, (23) Poland, (24) Portugal, (25) Slovak Republic, (26) Slovenia, (27) Spain, (28) Sweden, (29) Switzerland, (30) United Kingdom, and (31) the United States.

2.3.1.5 Exclusion criteria

I excluded:

1) randomised control trials
2) cohort studies
3) case-control studies
4) cross-sectional studies
5) clinical case studies
6) surveys
7) surveys with written open-ended questions
8) participants younger than 15 years
9) non-migrant women (e.g. ethnic minority women or second-generation migrant women who were born and raised in the country of migration)
10) and participants (migrant women) with no history of DV.

However, in cases where the above studies (i.e. randomised control trials, cohort studies, case-control studies, cross-sectional studies, surveys, and surveys with written open-ended questions) reported qualitative data that could be attributed to migrant women with experience of DVA, these studies were potentially eligible for inclusion.

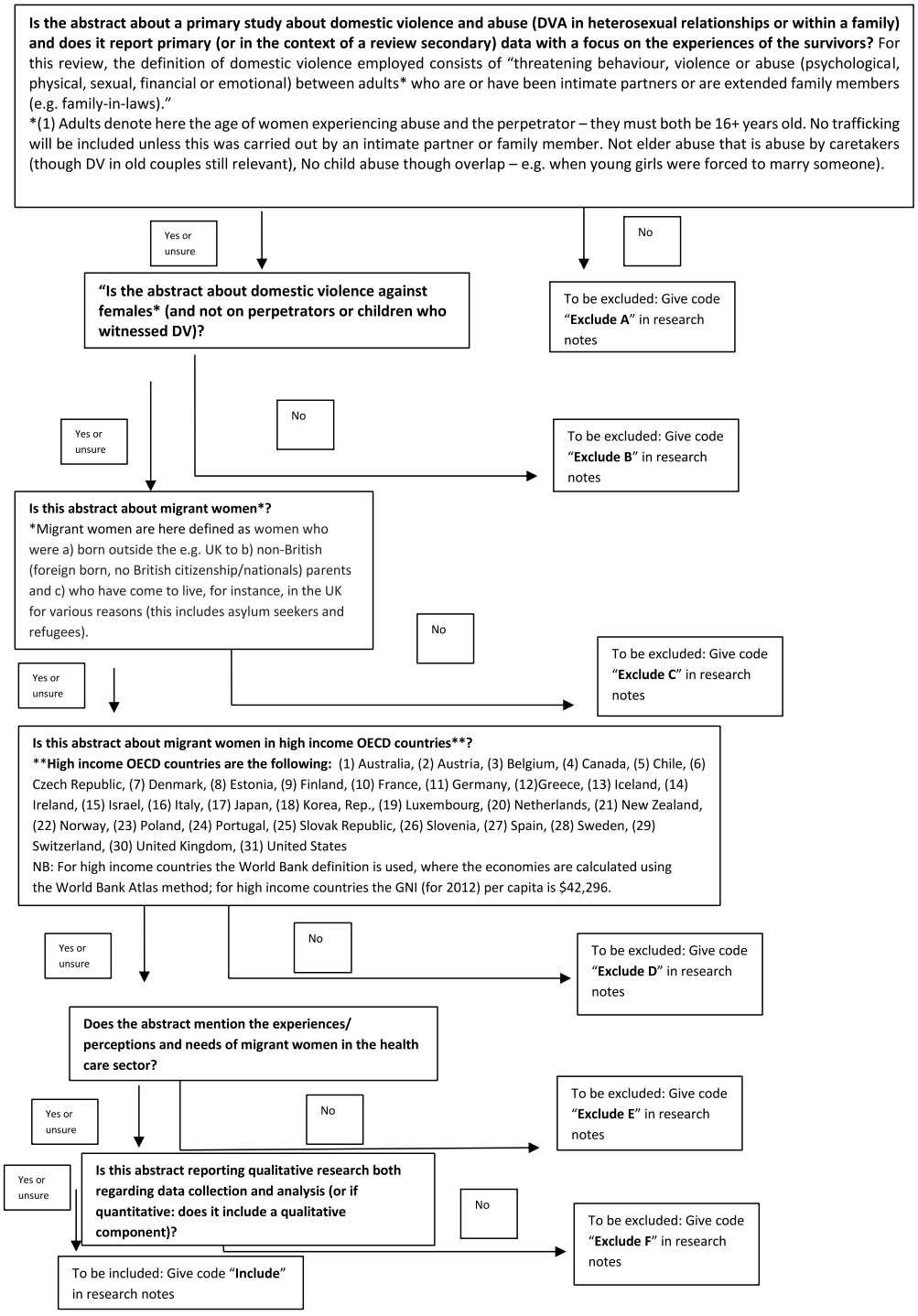
2.3.1.6 Selection and screening

Together with a second reviewer, I independently assessed the titles and abstracts of the identified records (n= 7834; after automatic deduplication n= 5358), these records include an update of my search in May 2018. To determine eligibility, the above stated inclusion criteria were used (as shown in Figure 2.1 below). Irrelevant titles and abstracts were

discarded. If a reference was deemed relevant by me or my second reviewer, we assessed the full text of that publication.

Figure 2.1: Decision-aid flowchart

NB In case of uncertainty or ambiguity at any stage of progress through the flowchart, continue to the next step rather than exclude an article prematurely.

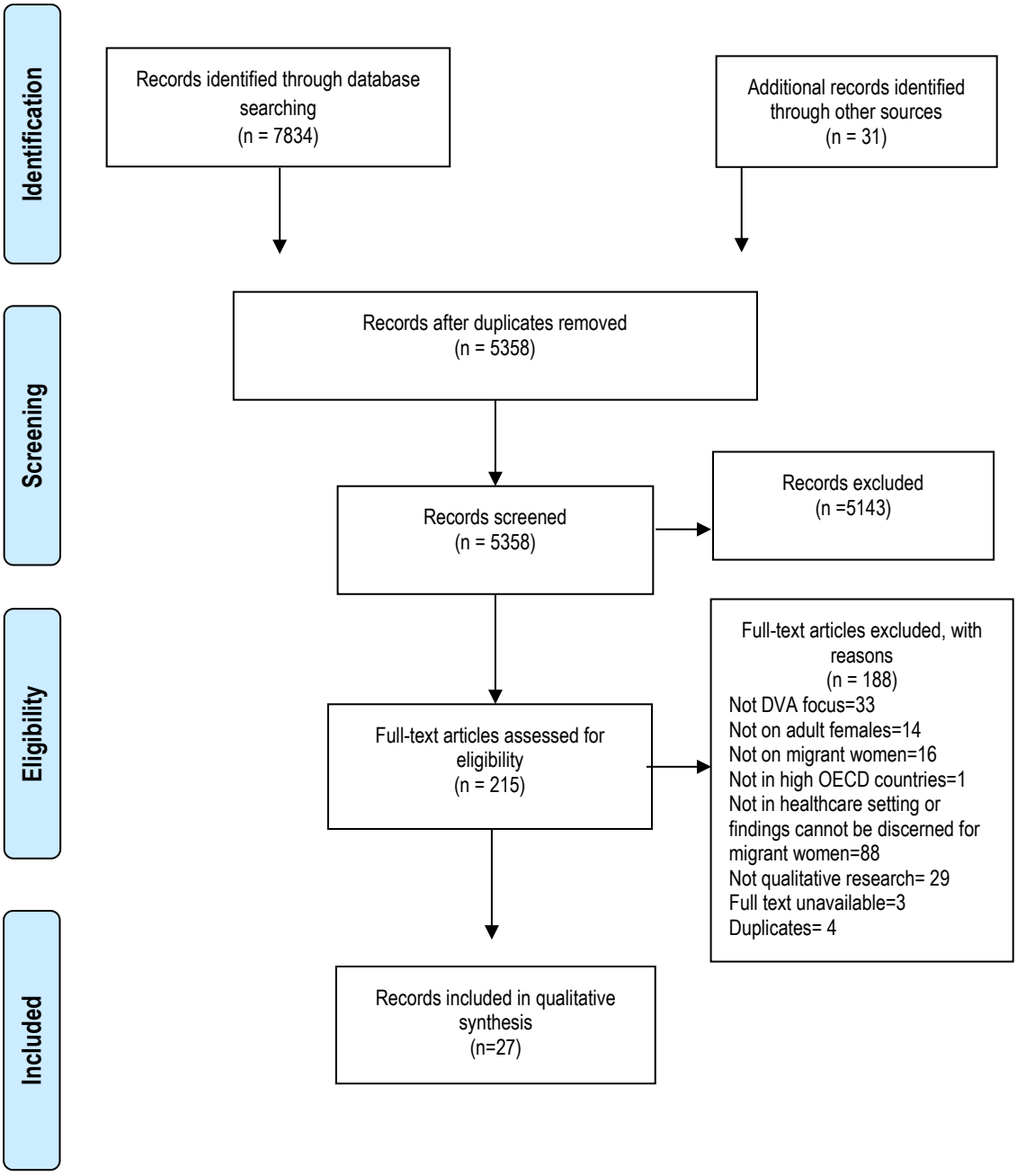


For 304 papers there was only a title available. These titles were screened using the same inclusion criteria (see Figure 2.1). For example, the title '*Libyan HIV trial is postponed*' was excluded based on criterion 'A' (not DV research). All the titles were screened and verified with one of my supervisors. Uncertain titles were further investigated; that is, first the abstract was located and, if necessary, the full text paper was then examined. The flowchart was not always followed in a linear way; for example, when the title indicated that the study was about women in an African country, then it would be discarded according to the criterion 'D'.

Finding relevant studies during the screening process resembled detective work, as the abstracts had to be read carefully to uncover hidden information: for instance, migrants were often described as 'ethnic minority women' or 'black and ethnic minority' (BME) women. Sometimes, a percentage or number included, for instance, Hispanic, Latina, Asian, Korean American or Tamil women. However, it was not always mentioned whether these women were first or second-generation women (i.e. whether they or their parents had migrated). This probably corresponds with the individual countries' policies regarding migration as, for example, Latina women form a part of the American population. Studies were included in which participants were migrants and if their results were presented separately and identifiable as derived from migrant women. For instance, in a US study by Nicolaidis and colleagues, 92% of participants were first-generation migrants, in others only a few first-generation migrant women were included. Some studies used the classification 'European Americans' (e.g. (194)), which raised the question whether these women had migrated from Europe or only had a distant European heritage. Similarly, when the abstract vaguely mentioned DVA, it was marked as 'unsure' and the full paper had to be read. Finally, when professionals or settings indicated healthcare, these papers also merited further examination.

Employing an iterative approach, I read and reread the identified full-text papers and decided whether the reported data was relevant to the aims of my review. I then used my flowchart as discussed before to justify my decision to include or exclude the study. For the full-text screening stage, I also sought help from a second reviewer. At this stage, multiple publications derived from one study were included. All 'unsure' papers were discussed with my second reviewer, and in the absence of a resolution, with my supervisors. Any disagreements regarding inclusion or exclusion were resolved by discussion. The PRISMA flow diagram below (Figure 2.2) illustrates the screening process and results.

Figure 2.2: PRISMA flow diagram for screening of studies



Source: Adapted from Moher and colleagues (195)

2.3.2 Qualitative synthesis: extraction of constructs and synthesis

In the following section, I will give an account of how I extracted and synthesised the data from the included studies using elements of meta-ethnography, as developed by Noblit and Hare (1988) and applied by others. (143, 156-161) As noted earlier, a meta-ethnography is an interpretive translation of qualitative studies into each other. Noblit and Hare emphasised the constructed nature of a synthesis and its product to be inevitably (at least

partially) tied to the synthesiser. For this, they used Geertz' (1973 (33)) argument that all ethnography is but interpretation of interpretations, whereby an ethnographer 'inscribes' the cultural interpretations of others, and as a result, creates a reading of culture. (p. 25 (155)) Hence, the meta-ethnography adds yet another layer of interpretation. The translation's outcome then reveals how the different studies relate to each other and creates a new overall interpretation – that of the reviewer/synthesiser.

Noblit and Hare's meta-ethnography (155) was adapted by others in applied health research (143, 158, 159, 161, 196). Britten and colleagues (2002) (159) successfully used elements of this approach to analyse, interpret and synthesise qualitative research. They demonstrated that this approach could produce middle-range theories in the forms of hypotheses, which extended beyond the original results of the individual study. (159) This was relevant for my research, as I also sought to identify the experiences and support needs across a wide range of abused migrant women to develop new conceptual insights that would further the original studies. This approach was also chosen as it takes context and interpretations of the original authors into account, using the authors' themes and interpretations as data, rather than re-analysing the data in the papers (e.g. verbatim quotes from participants) using new themes generated by the synthesis team – as is typical in thematic synthesis. (175) Noblit and Hare suggested seven steps to undertaking a meta-ethnography (see Table 2.2 below); steps 1-3 have been covered here in the systematic review section (see 2.3.1).

Table 2.2: Steps for undertaking a meta-ethnography

Seven steps of Noblit and Hare's meta-ethnography
1. Getting started
2. Deciding what is relevant to the initial interest
3. Reading the studies
4. Determining how the studies are related
5. Translating the studies into one another
6. Synthesising translations
7. Expressing the synthesis

Source: Adapted from Britten and colleagues (159)

Three types of synthesis were advocated by Noblit and Hare (155): (1) reciprocal translation, which is used when studies 'are about similar things' ((155) p. 38) to translate these studies into one another; (2) a refutational synthesis, which is used when studies 'refute each other' ((155) p. 38) and to interpret conflicting accounts; and (3) a line-of-argument synthesis, which can be used to 'successively 'build' a line-of-argument' inferentially ((155) p. 38) and achieve an overarching interpretation that explains the individual studies and the relationships between them.

> *Like clinical inference, the goal of lines-of-argument synthesis is to discover a "whole" among a set of parts. Like ethnographic accounts, it is emic (Spicer, 1976 (197)) in its allegiance to the studies being synthesized; it is historical in that it uses time to give order and history-in-use to give context; it is comparative in that it constructs an analogy of the relationships among studies; and it is holistic in that it constructs an interpretation of all the studies, their interrelations and contexts. ((155) p. 63))*

However, there can be an overlap between, for instance, the reciprocal and line-of-argument synthesis, or even between all three synthesis types. There can be agreement within and across studies and also intrastudy conflict or contradiction (i.e. a conflict within a study) or interstudy conflict (i.e. a conflict between studies). (143) For my synthesis, I mainly used the line-of-argument approach.

2.3.2.1 First, second and third-order constructs

As outlined earlier, Britten and colleagues (2002 (159)) were the first researchers to apply Noblit and Hare's ethnography (155) successfully to the health research setting using studies other than ethnographies. However, they slightly adapted it by introducing Alfred Schütz's (198)[27] phenomenological notion of order of constructs (namely first and second-order constructs), whereby the first-order constructs refer to the 'everyday understandings of ordinary people' and the second-order constructs represent 'constructs of the social sciences' (i.e. the authors' interpretations, theories and explanations based on the everyday understandings of their participants). (159) Britten and colleagues (2002, (159)) showed that this idea of first and second-order constructs could be used in synthesis processes, as proposed by Noblit and Hare (155), to develop so-called third-order constructs – interpretations or higher-level abstraction.

In this thesis, first-order constructs represent the experiences and needs as described by migrant women (i.e. expressed in verbatim quotes in the papers) and second-order constructs denote the authors' interpretations and conclusions, their themes and conceptualisations derived from their data (see Figure 2.3 below). Third-order constructs

[27] Schütz is the correct spelling of his name, although, probably due to moving to the US during World WarII, his name was often changed to Schutz in his publications. I will refer to him as Schütz here.

represented new overarching constructs across all identified papers – these reflect my own interpretations. Having defined the different levels of constructs, I will now turn to the actual extraction and synthesis process.

Figure 2.3: Visualising the different types of constructs

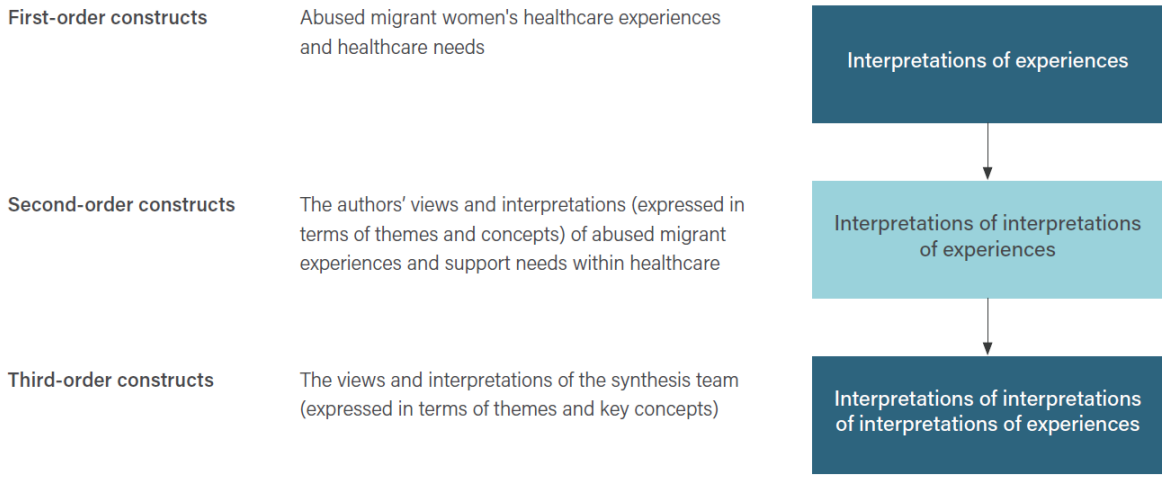


Table adapted from Malpass and colleagues (161) who drew their working definition of first, second and third-order constructs from the work of Noblit and Hare (155) and Britten and colleagues (159).

2.3.2.2 Extraction of data and constructs

As a first step, I extracted the following study details: author name(s), publication date, country, aim of paper, setting, methods of data collection and analysis, participants' characteristics, country of origin and duration of stay in the country of residence, abuse type, duration and perpetrator(s), contact with clinician and type of clinician, and relationship status and items relating to study quality. This was done to preserve each study's context - to be considered when analysing and synthesising the findings.

Next, after reading the papers, I identified and extracted first and second-order constructs (see Figure 2.3 above) from the results and discussion sections of the papers, drawing on the approach described by Britten and colleagues (159), as well as others. (143, 156-158, 160, 161)

I extracted these two types of constructs onto a form into two different columns, using a standardised data extraction form (see Appendix 3). Here, the second-order constructs were illuminated by raw data - that is, first-order constructs. Second-order constructs were also extracted if the authors applied their findings to constructs found by other authors in previous studies. A third column provided space where I could note my ideas and additional interpretations to inform the development of third-order constructs.

Other reviewers helped me extract constructs and write down any additional comments or ideas, so that each paper effectively had two completed extraction forms. As the other researchers were relatively unfamiliar with my topic, they provided an unbiased and uninformed perspective. It should be noted that the double extraction was not carried out to ensure to inter-rater reliability, but rather to incorporate other perspectives in the identification of existing constructs and development of new constructs. Although highly useful, the reviewers' unfamiliarity with the topic occasionally led to them missing relevant data – for instance, an undocumented immigration status which impacted the healthcare access and interaction with healthcare professionals. In such instances, I adopted a pragmatic approach, in that the number and types of constructs found did not have to be identical; only when the constructs identified differed substantially or an apparently relevant construct was absent did I discuss this with the other reviewers. This mirrors Barbour's position (2001 (185)), which stated that what matters is not the degree of concordance, but rather the degree and content of disagreement. Here, a discussion proved fruitful in refining second-order constructs – yet, in most cases the identified second-order constructs only slightly varied in the way they were worded.

2.3.2.3 Translation of studies

All the first and second-order constructs identified by the reviewers were then combined in one single Microsoft Excel document. This was followed by a process of translation, where I compared second-order constructs across the studies. I particularly focussed on the second-order constructs (while still retaining and checking them with relevant first-order constructs, which illuminated the second-order constructs). This made it possible to see how the same experience or phenomenon experienced by migrant women was worded or interpreted differently by different authors. This, is in turn, allowed me to create third-order constructs – that is, overarching constructs across all identified papers, which reflected my own interpretations.

2.3.2.4 Synthesis of studies

I iteratively translated studies into each other using a line-of-argument synthesis. This synthesis approach was appropriate as I wanted to give an overall account of migrant women's healthcare experiences. By arranging the constructs in an order (e.g. a temporal organising order, such as pre-consultation barriers), I aimed to provide a more comprehensive understanding of the healthcare experiences and needs of migrant women affected by DVA – ultimately, to create an overarching argument or conceptual model of what the set of studies reported. (199) I also used diagrams to aid visualisation of the

identified relationships of the constructs in the next chapter. All findings were re-interpreted and synthesised by me, with feedback from my supervisors.

2.3.3 Quality appraisal of studies and sensitivity analysis

I briefly discussed the issue of quality appraisal earlier. There are a number of instruments for appraising the quality of qualitative studies, but many of these have not themselves been evaluated (200), and all of them have limitations (e.g. being too lengthy or containing many irrelevant items). This is not surprising, as there is no agreement regarding which quality criteria is most appropriate for qualitative research. (189) According to a recent systematic review of qualitative syntheses, the Critical Appraisal Skills Programme (CASP) is a popular appraisal instrument. (201) CASP was used by Feder and colleagues (143) and other healthcare researchers (159, 161, 196, 200) and was found to be valuable and appropriate. Thus, I used CASP to assess the quality of my included studies. (160)

CASP is based on ten questions and hints (160). These enquire about various aspects of the study. For instance, CASP enquires whether the research or findings are clearly reported and assesses the appropriateness of methodology. Furthermore, ethical aspects are assessed, as well as the extent of reflexivity and the rigour of analysis. A maximum score of 10 points can be reached if all questions can be answered with a 'yes'[28] – other possible answers are 'unsure' and 'no'. Another reviewer and I independently rated each of the included studies using CASP. Any disagreement was resolved by discussion. If no consensus was reached, my supervisors were consulted and resolved the issue. Drawing on Feder and colleagues' finding (143) that a system of weighting the CASP scoring was relatively insensitive regarding which of the four weighting systems had been employed, we used a simple score of the studies (e.g. a maximum 10-point CASP score).

Following on from my previous discussion on relevance and quality, I did not use CASP to exclude any publications, but rather to examine which studies contributed to which constructs and to employ the quality appraisal results in a form of 'sensitivity analysis', that is, to see whether removing studies which scored lower on CASP would have an impact on the overall synthesis. The findings from this sensitivity analysis will be reported in my next chapter.

2.4 Chapter summary

In this chapter, I have described the methods for my systematic qualitative review to identify and synthesise the healthcare experiences and needs of migrant women affected

[28]Oher non-scoring answer choices are 'unsure' and 'no'.

by DVA. First, I carried out a systematic literature review. Next, I synthesised the studies using elements of an adapted meta-ethnography, where I identified and translated first and second-order constructs of the studies and translated these across studies to develop third-order constructs that were then used in a line-of-argument-synthesis. I also appraised the quality of included studies using the CASP checklist for qualitative studies and conducted a sensitivity analysis. In the next chapter, I will present my synthesis findings.

Chapter 3: **Findings of the qualitative synthesis**

3.1 Introduction

The aim of this chapter is to report the findings of my qualitative synthesis, including the quality appraisal and sensitivity analysis. The aim of my synthesis was to identify the healthcare experiences and needs of migrant women with DVA experiences.

Specifically, my objectives were:

1. To identify the healthcare experiences among migrant women with histories of DVA
2. To identify how these women found support following exposure to DVA
3. To identify any unmet support needs among these women

First, I will provide an overview of the included studies. Next, I will describe and discuss the three overarching constructs I derived, namely: 1) constrained help-seeking and help-receiving, 2) conditions and triggers for disclosure and pathways to support, and 3) person-centred care experienced and needed. These were built on constructs identified and translated across papers. (155) Constrained help-seeking and help-receiving addresses the healthcare experiences and barriers (objective 1). Conditions and triggers for disclosure and pathways to support describe circumstances for disclosure which *could* lead to finding support (objective 2). Person-centred care experienced and needed describe migrant women's positive healthcare experiences and needs (objectives 1 and 3). Next, I will describe my line-of-argument synthesis (155), where I combined the three overarching constructs together to give an overall conceptual account of migrant women's healthcare experiences. Following this, I will describe the quality appraisal and sensitivity analysis of the publications. Finally, I will discuss the strength and limitations of my synthesis findings and suggest further research. I will discuss my synthesis findings in relation to the wider literature in the discussion chapter (see Chapter 6).

3.2 Overview of studies

This synthesis is built on 27 publications (202-228) these were based on 24 studies. One study produced three (202-204), and the other one produced two publications (210, 211), each publication focussing on different findings.

In total, the qualitative synthesis included 431[29] migrant women with histories of DVA. The studies differed considerably in the socio-demographic and other information they provided (see Appendix 4). Where reported, women were aged between 16-68 years (e.g. (226)) and a large proportion had dependent children (e.g. (202-206, 208, 210-212, 214, 217, 219, 223, 224, 226)), many of whom were underage (e.g. (206, 212, 224)). The educational background of the women ranged from no education and being illiterate (e.g. (202, 206, 210, 214, 217)) to having completed university degrees (e.g. (202, 204, 210, 223, 226)).

Some women were undocumented in their country of residence (e.g. (217, 223, 226, 227)) or were seeking asylum (214), while others were dependent on their husbands for their immigration status (e.g. (218, 223, 226)) or had acquired citizenship or an independent immigration status (e.g.(214, 224)). Where reported, the number of years lived in the country of residence varied considerably: the time ranged from less than a year (e.g. (206, 223)), to five years (e.g. (214, 219)); less than ten years (e.g. (205, 211, 212)) to more than ten years (e.g. (208, 214, 216, 221, 226)), to more than 20 years (e.g. (214, 226), (up to e.g. 43 years (221)). In most studies (n=17) (202-204, 206-208, 210-221, 223, 225-227), interviews and focus groups were conducted, at least in part, in the women's native languages (e.g. (202-205, 209, 223), sometimes with the help of an interpreter (209, 218, 228) due to many women's lack of proficiency in English.

3.2.1 Migrant women's country of origin and country of residence

12 studies (206, 207, 209-211, 213, 215, 217, 219, 221, 225-227) were conducted on Hispanic/Latina migrant women[30]; of these, 11 in the US and one in Canada (226). This was followed by eight studies (205, 208, 214, 216, 218, 220, 223, 224) on Asian migrant women in the US, UK and Canada (205, 208, 214, 216, 218, 220, 223, 224), with one study on Saudi

[29] This is an approximate number due to some studies only reporting a percentage and not clearly distinguishing between migrant women when including them as a subsample.

[30] I will use the terms Hispanic and Latina interchangeably to refer to women coming from diverse Latin American countries. While this umbrella term (like Asian) is not undisputed (as according to the Pew Research study), 51 % of people from Latin America generally prefer describing their identity in terms of their family's country of origin over pan-ethnic terms http://www.pewhispanic.org/2012/04/04/when-labels-dont-fit-hispanics-and-their-views-of-identity/), these terms were used in the respective studies, which often included women from diverse countries and these terms were therefore used in this thesis. Wherever possible, I will state the country of origin of the women.

Arabian women in the UK (223) and one study on Vietnamese women in the US. (208) One US study examined both Hispanic and Asian women (202-204), while a study each was also carried out on Polish women in the US (212), African and Caribbean women in the UK (222) and diverse migrant women in Norway. (228) 15 studies were carried out in the US (202-204, 206-213, 215, 217, 219-221, 225, 227); six studies in the UK (205, 214, 218, 222-224), two studies in Canada (216, 226) and one study in Norway. (228)

Table 3.1 shows the migrant women's countries of origin. Some studies did not specify were the women had come from (for a full overview see Appendix 4) but instead used umbrella terms such as 'Caribbean and African countries' (222) and 'Central America and Spanish Caribbean countries'. (215) One study referred to one woman as being from 'South East Asia'. (205) Therefore, these women are not included in the Table 3.1 below.

Table 3.1: Migrant women's countries of origin

Country of origin	Number of studies	Number of participants n=339
Mexico	n=10 (202-204, 207, 209-211, 213, 217, 221, 225-227)	n=103
India/Kenya	n=4 (214, 216, 220)	n=83
Vietnam	n=2 (202-204, 208)	n=35
Saudi Arabia	n=1 (223)	n=20
Puerto Rico	n=4 (206, 209, 219, 227)	n=13
Colombia**	n=4 (202-204, 209, 226, 227)	n=10
Pakistan****	n=4 (205, 214, 216, 228)	n=9
El Salvador	n=4 (202-204, 209-211, 226)	n=8
Guatemala	n=4 (202-204, 209-211, 226)	n=6
Poland	n=2 (212, 228)	n=6
Dominican Republic	n=2 (226, 227)	n=5
Bangladesh****	n=3 (214, 216, 218)	n=5
China	n=1 (202-204)	n=5
Honduras	n=3 (209, 213, 226)	n=4
Philippines	n=1 (202-204)	n=4
Afghanistan***	n=1 (214)	n=4
Sri Lanka and Nepal****	n=1 (214)	n=4
Nicaragua	n=2 (210, 211, 227)	n=2
Korea	n=1*(202-204)	n=2
Peru	n=1 (226)	n=2
Taiwan	n=1* (202-204)	n=2
Indonesia	n=1 (224)	n=2
Iraq	n=1 (228)	n=1
Turkey	n=1 (228)	n=1
Spain	n=1 (228)	n=1
Argentina	n=1 (226)	n=1
Venezuela	n=1 (213) **	n=1

Key: *Some studies elicited more publications; thus, n refers to the number of studies, which may not correspond with the number of references.
**One woman was born in Colombia but raised in Venezuela.
***These Afghan women were reported to have lived as refugees in Pakistan.
**** In one study (214), the country of origin was not clearly discernible as it only stated women's ethnicities instead of their country of origin and 25% were non-migrant women, consequently these women were not included.

3.2.2 Information about included studies

Most of the studies (n=14) recruited women from DV agencies (202-205, 207-212, 214-219, 221, 222, 224, 226-228); this was followed by healthcare (n=4 (206, 213, 218, 220, 222,

225, 226)), DVA and healthcare services (222) or community settings (222, 226) and the Saudi Arabian embassy. (223). Sample sizes ranged from two (224) to five (225) to 65 migrant women. (220) While 14 publications included migrant women only (203, 204, 206-213, 216-220, 223) nine included migrant women as a subsample alongside non-migrant women and/or professionals. (202, 203, 205, 214, 215, 217, 219, 221, 222, 224)

The aim of the majority (n=14) of studies was to investigate the help-seeking experiences (including barriers) of migrant women with histories of DV healthcare. (203-205, 208-216, 218, 223, 225, 227-229)The focus of other studies included: women's perceptions of depression (206, 221); the impact of DVA on mental health (226); DV screening (207); DVA experiences and recommendations on how midwives should communicate about DVA (228); disclosure of DVA (217); psychological violence (222); and reproductive coercion. (220) Not all studies focussed on healthcare; if they did, the healthcare settings differed, with some investigating general healthcare (202-204, 207, 209, 210, 216), primary care (218, 222), mental healthcare (206, 211-214, 221), health visiting (205, 224), midwives (228) or reproductive health clinics. (220)

Some study designs were informed by feminist theories (n=7 (205, 206, 209, 216, 222, 224, 226) or ethno-nursing (n=1 (207)). Four studies reported a phenomenological design (209, 211, 212, 224), three a community participatory research approach (214, 219, 221) and two used a grounded theory approach (217, 222), with one study combining this with an ethnographic approach. (217, 229)

22 publications were based on interviews (205-209, 212-215, 217, 218, 220, 222-228), four used focus groups (202-204, 210, 211, 216, 221) and one used listening sessions. (219) Six studies employed thematic analysis (207, 214, 216, 221, 223, 228), four stated that they had analysed their data thematically (202-204, 207, 214-216, 220, 221, 223, 227) while one study used a combination of framework and thematic analysis. (213) Five publications employed different content analysis approaches (210, 211, 218, 219, 224, 226) and one used a phenomenological approach. (212) Three studies did not state how they analysed their data (206, 208, 220), while four studies utilised a Grounded Theory approach, as suggested by Charmaz. (217, 222, 225)

3.2.3 Women's DVA experiences, migration trajectory and health

In this section, I will briefly summarise migrant women's DVA experiences, perpetrators and migration-DVA trajectories and health consequences.

The authors' use of terminology varied (e.g. DV vs IPV) as did their foci of violence (e.g. psychological violence (222) vs reproductive coercion (220)), its duration (e.g. lifetime, historic vs current abuse) and range of perpetrators (e.g. partner/husband vs other family members). Studies reported psychological (209-211, 222-224, 226), emotional (214, 218), physical (202-204, 206, 209, 212-214, 223) and sexual violence (206, 209, 214, 220, 223, 224, 226); reproductive coercion (i.e. pressure to conceive or terminate pregnancies) (214, 218, 220, 223) – particularly when the foetus was found to be female (220); forced marriages[31] (209, 214, 218); polygamy (222); emotional neglect (i.e. complete lack of interest in and companionship of women) (214, 218); coercive control (e.g. no access to telephone) (214, 218, 228), including enslavement and imprisonment in the home (206, 214) and restriction or denial of breastfeeding (214, 224); cultural isolation by not allowing women to mix with non-migrant or more acculturated women (222); and financial violence. (e.g. (214, 224)) These forms of violence frequently overlapped and some of these are captured in the quote below:

> *Everyone was like fire towards me. Swearing at me, father-in-law, brother-in-law, everyone …They used to say 'You are from Bangladesh', there was no sympathy, even though I was doing housework, they hated me, all of them used to hate me. I don't know why. I said to my mother-in-law even though I was not happy with my husband, why does everyone hate me, they don't like me, and call me bad names, but she just said, 'If you want to stay in my house you have to listen to everything, you can't say a word'. Then she kicked me and said 'Get out from my house'. It's like you can't say anything even though they treat you badly. Sometimes my mother-in-law used to swear about my parents in Bangladesh because they married me with her boy …They threatened me that they would kill me. For two days I was without any food, nothing, I was so scared, so upset, brother-in-law he was saying 'why aren't you cooking?' […][32]*
>
> *((214) p. 14) Bangladeshi woman in the UK*

A few studies also reported women's experiences of childhood abuse, which could be sexual (221, 226), physical (206, 209, 224), psychological or other (not letting women attend school). (206) Other studies reported experiencing war or political conflict (208, 226) and living in violent neighbourhoods. (206)

Several studies provided insight into the DVA trajectories in relation to migration. (e.g. (206, 208, 212, 214, 216, 218, 220, 222-224)) In most cases, migration made women more vulnerable to experiencing DVA. For some women, the migration represented the simultaneous start of their relationship (206) and/or forced or arranged[33] marriages (including consummation of marriage) (e.g. (214, 216, 218, 220)) and violence. For other migrant women, DVA was a continuous experience: they had encountered it before leaving

[31] Some forced marriages were reported at a young age (below the age of 16 years), so there was some overlap with child abuse.
[32] […] indicates when I have shortened quotes from the included papers.
[33] The boundaries between arranged and forced marriage were often unclear and there was some overlap.

their country of origin before migrating by either their partner (208, 224) or previous partner/s (206) during migration (208); in some cases, this then continued and was exacerbated after migration by either the same (208, 212, 224) or a new partner (206) and/or the family-in-law. (209, 214, 216, 218, 220, 226) Some studies found its onset to be related to pregnancy (209, 214, 218, 220, 223, 224, 228), which could also include pressure to become pregnant and specifically to give birth to sons (220), or exacerbated during pregnancy (e.g.(209, 214, 218, 224)).Conversely, in two studies women reported a positive effect of migration as it removed them from the perpetrator/s (206), including the conflict-instigating influence of the husband's family. (223)

The above studies show that some women had encountered multiple forms of violence by multiple perpetrators throughout their lives. This, in turn, impacted their physical and mental health, with injuries (e.g. (209, 226) including: headaches, sexually transmitted diseases (e.g.(226)), heart palpitations, numbness (221), fainting, pain, insomnia, weight loss or gain. (226) Most studies also reported symptoms of emotional distress, especially depression (e.g. (226) and anxiety-related symptoms, as well as flashbacks indicative of post-traumatic stress disorder (PTSD). Studies also reported suicidal ideation (216) or even suicide attempts. (206, 214)

Having given some context through the above studies, I will now present my findings.

3.3 Overarching constructs

In the following section, I will describe and discuss my three overarching constructs and line-of-argument synthesis.

I first identified 28 second-order constructs (i.e. the originals authors' interpretations or themes) in the studies and translated these into each other. (155, 159) A full overview of the constructs can be seen in the table in Appendix 5. This table provides a list of all the second-order constructs from the 27 publications. It uses the authors' original words, or paraphrases the author, and provides a narrative translation of each construct, which is meaningful for each publication where it was located. The table also differentiates publications according to their respective CASP score, which will be discussed in section 3.4.

Based on the translation of 28 constructs, I derived three overarching constructs: (1) constrained help-seeking and help-receiving, (2) conditions and triggers for disclosure and (3) person-centred healthcare received and needed. Each overarching construct comprises several sub-constructs. While constrained help-seeking and receiving reflects healthcare

experiences and barriers before and/or during a consultation, the second construct represents conditions for disclosure in healthcare. Person-centred care received and needed describes both positive healthcare experiences and needs. Where appropriate, I will illuminate my constructs with quotes from the authors, or the women in the studies, and discuss discrepant constructs. The figures presented in each overarching construct offer a conceptual presentation of each. To create an overall conceptual account of migrant women's healthcare experiences and needs, I used a line-of-argument synthesis by combining my overarching constructs and arranging them in a temporal order, as shown in Figure 3.4.

3.3.1 Constrained help-seeking and help-receiving

Migrant women's help-seeking and help-receiving in healthcare was 'constrained'. I have borrowed the term 'constrained help-seeking' from Anitha and colleagues (214) and extended it to help-receiving. I will now discuss the many barriers encountered by women when accessing healthcare. These were broadly divided by some authors into socio-political and socio-cultural barriers.(e.g. (203))

3.3.1.1 Healthcare access barriers due to lack of resources

Healthcare access was impeded by many intersecting factors related to cultural and political reasons, such as immigration status and finances.

Due to cultural reasons, some women did not perceive their violent experiences, particularly psychological or sexual violence, as abuse. (202, 204, 211-213, 216, 222, 223, 228) This shaped their responses, including accessing healthcare. Migrant women often lacked general knowledge about sources of help (e.g. laws against DVA, organisations of help) (204, 208, 209, 211-213, 216-219, 222, 223, 225, 227, 228) and specifically about healthcare due to lack of information, social contacts and lack of language. (204)

> *I was not aware that violence was forbidden in Norway, that there should not be violence, and that it would be against the law.*
>
> *((218), p. 5) Pakistan woman, Norway*

Language barriers made it difficult to contact services and this was exacerbated by unsuccessful attempts. (222) Healthcare was found to be difficult in general, '*bureaucratic*'[34] and often '*confusing*' to navigate. (209) Women did not know whom to see for which problems; for instance, (209) some women used emergency care for panic

[34] Words used by migrant women as cited by authors or authors' words will appear in quotation marks and italics.

attacks. (209, 221) There was a lack of knowledge as to *'what basic healthcare meant',* ((215) p. 1495), with some women assuming they received basic healthcare by being tested for HIV every year, when they did not. (215) In one study, only 15% of Latina women had a primary care provider. (221) Women '*were unfamiliar with the concept of primary care*' and continuity of care (209) and believed that they had to see *'whomever they were given for each appointment'* without being able to choose. (209) For instance, one woman saw a different HCP for her annual examination for several years and this prevented her from building a trustful relationship with a single HCP. (209) This reflected a dissatisfactory relationship between women and HCPs, and this was likened by Kelly (209) to persisting in abusive relationships.

> *Many of the women did not know they could change HCPs if they were unhappy with the care they were receiving, so they persisted in these disappointing relationships, just as they did with their abusers.*
>
> *((209)) p.146, Latina women, US*

Some migrant women, particularly undocumented (209, 217) and uninsured ones (209, 211), were unaware of free healthcare (209, 211) and believed that they did not '*have the right to get sick*' because everything required '*papers*'. ((211) p. 68) Lack of health insurance or the cost of healthcare (209, 210, 215, 221), lack of social security number (227) and immigration status (209, 227) were also barriers to accessing healthcare. Lack of immigration status and fear of deportation (209, 217) led some abused migrant women to live '*under the radar*' (209) and these women were therefore invisible to healthcare. Other migrant women did not have the financial means (214), or knowledge of *how* to access healthcare, for instance, by taking public transport. (214) The remote location and poor provision of mental healthcare in certain rural areas was also a barrier. (206, 211, 214)

The cost of healthcare, particularly mental healthcare, including prescriptions, was often prohibitive. (211, 215) If access to healthcare was restricted, abused migrant women often prioritised their children's health. (207, 209-211) Lack of childcare made healthcare access and interactions with HCPs difficult. (210, 214) Moreover, long waiting times were an additional obstacle (204, 209-211, 219, 226), often related to lack of language (i.e. waiting for an interpreter) and also to discrimination (211) or insurance status. (221) One US study further found that long waiting times were also a financial obstacle due to loss of work time. (210, 211) Thus, some women only sought healthcare during vacations. (210) It should be noted that long waiting times could also trigger further violence. (210, 211)

Some migrant women sought healthcare very late due to the above barriers. (209, 212, 216, 217) To alleviate their symptoms (214), GPs, family physicians or community clinics were

often the first port of call (209, 213, 214, 222, 223, 225, 227) – sometimes because migrant women only knew about them ((214) p. 79) and/or could access them. (209, 214, 222, 223)

Despite some women having partly frequent interactions with their HCPs (209, 214) and attributing their (mental) health symptoms to DVA, many did not disclose this, some even denied or lied about it. (209, 211, 212, 214, 216, 217, 220-222, 226) However, not all women made the link between DVA and their or their children's health. (213, 214)

> *[…] women's initial efforts are often geared towards managing the trauma of abuse by focusing on the symptoms in an attempt to alleviate some of it, and far from being passive and helpless victims, they may make partial disclosures, resort to constrained help-seeking without naming the problem, test service responses and confidentiality.*
>
> *((214), p. 77) Asian women, UK*

Some women did not attribute their mental or emotional issues solely to DVA but linked this to other violent experiences, such as childhood abuse (221, 226) and loss of social network due to migration. (226) Furthermore, some women felt that keeping the violence inside, due to having no one to speak to, exacerbated their depression. (221)

Non-disclosure of DVA was also shown to be related to feelings of shame, coercive control, fear of the consequences of disclosure (e.g. deportation and loss of children) and healthcare expectations (i.e. not perceiving DVA a healthcare issue) and lack of language. HCPs' responses, including lack of time, focus on symptoms, and discrimination, language barriers and lack of language provision were also barriers. Non-disclosure could also be caused by a combination of these factors. I will detail these in the following.

3.3.1.2 Feelings of shame and other emotional responses

Emotional responses to DVA were powerful barriers to disclosure. Cultural and religious values, such as collectivism, patriarchy and familism, influenced how DVA was perceived *('a cross to bear'*), normalised and emotionally responded to (e.g. feelings of shame, self-blame minimising/denial). (202, 204, 216, 222, 223, 226, 228) This impacted which coping strategies were used (e.g. using private coping skills such as praying) and presented a huge barrier for migrant women across studies. (202, 204, 216, 222)

> *In the beginning, women went through disbelief and minimization. Then, they tried to tolerate, sacrifice themselves, pray to God and change themselves in order to meet the culturally prescribed expectations for a 'real woman' (i.e., silence, marital obligation, subordination), and for the sake of children while avoiding social stigma to preserve family respect.*
>
> *((216) p. 618), Asian women, Canada*

Many women perceived DV to reflect badly on them as wives. (204) DV was considered private, not to be disclosed, as this would bring shame to the women and their families (202, 204, 208, 209, 211-214, 216, 218, 220, 223); separation and divorce was also stigmatised across migrant women. (204, 208, 211, 212, 216, 218, 222, 223) Women's gender roles often centred on motherhood and preserving the family unit. (204, 208, 209, 211, 212, 216) Asian women appeared to be ashamed – even more so for their parents and children because of the societal repercussions, such as stigma, '*loss of respect*' and ostracisation. (204, 208, 209, 211, 212, 216, 223) Thus, many women remained silent. Depression could also be a barrier to seeking help. (227) These emotions were as much of a barrier to interaction with HCPs as with family and friends. (202, 209, 212, 214, 216, 220, 222, 223)

> *Women talked about social stigma or shame on disclosure of domestic violence. Such disclosures were perceived to bring suffering and loss of respect, especially for their family and parents. Some women discussed their worries about "parents' suffering" more than themselves due to the social stigma associated with an unsuccessful marriage of one's daughter.*
>
> *((216) p. 617) Asian women, Canada*
>
> *I didn't tell my own family, why would I tell a doctor? I was very strong at that time…*
>
> *((216) p. 617) Asian woman, Canada*

Other women were silent to spare their family suffering (209, 212, 222), particularly their mothers (209, 212, 217, 223), and/or because they did not want their families to interfere or retaliate. (209, 223)

3.3.1.3 Lack of social support: pressure and coercive control

As said above, women were lacked social support due to migration. (202, 204, 206-209, 211-213, 216, 218-220, 222-224, 226, 228) Some authors (204, 211, 216) described the impact of lack of support and social isolation on help-seeking.

> *The loss of social networks and extended family system after immigration accentuated the delay in women's help-seeking through depleted quality and quantity of both emotional and instrumental support*
>
> *((216) p. 617) Asian women, Canada*
>
> *Yes, that is our problem. When you arrive here, you don't know anyone, so who are you going to tell? You have to keep your problems to yourself. That's why you get depressed, because you don't have anyone you trust enough to confide in. There's no way you're going to call home to tell of all the problems you have here.*
>
> *((205) p. 36) Latian women, US*

The above quote describes the impact of lack of social support when encountering DVA. Migration on its own may impact mental health due to loss of social network. Yet this is even more pronounced when facing DVA and having no-one to confide in. As said above, migrant women were reluctant to involve family. In one study, several women perceived their families to be '*sealed containers*' rather than being protective and emotionally supportive. ((213) p. 64) This sentiment was echoed in other studies. Similarly, friends were often unsupportive. The church or religious leaders also often played a similar silencing role. (208)

Across studies, as said above, family and friends were found to be largely unsupportive in the women's efforts to leave the abusive relationships. Instead some were even complicit in the abuse (209, 214, 218, 220, 226) either overtly or covertly (209), for instance, by blaming the women (209, 216), pressuring them into staying (208, 211, 218, 222) and keeping silent. (207, 209, 212, 214, 216, 218, 220, 224) Here, relatives emphasised the children's wellbeing (208, 209, 211, 212, 214, 218, 220, 222, 224) or punishment by God. (205) Threats of violence (209), deportation (204, 208, 209, 211, 212, 214, 218, 220, 224) and/or loss of children (203, 208, 209, 217, 218, 220, 223) were used by the perpetrator(s). This coercive control and threats impeded disclosure in healthcare. (202, 204, 208-212, 214, 218, 220, 223, 224, 228) Language barriers exacerbated this, for instance, when husbands were used as interpreters (207, 228) and this way controlled the communication. (207, 218)

> *The women's and the abusers' families had powerful influences on these women's lives, both overt and covert. In most cases, familial influences further isolated these women. In a few cases, the abuser's family was an extension of the abuser, in terms of controlling behavior and threats.*
>
> *((209) p. 74) Latin women US*
>
> *My mother say don't come back here, India…Your brother you see he's going to kill you. That's why you don't come. You stay in London, you die, die there. Don't come back.*
>
> *((218) p. 16) Indian woman, UK*

The women's husbands or partners and/or (extended) families also used coercive control to restrict women's help-seeking by, for instance, not allowing them to seek healthcare, including antenatal care (224), or accompanying them. (207, 209, 220, 224, 228) In contrast, one US study found that pregnant South Asian women were pressured by their husbands and in-laws to have scans to determine their foetus's sex and terminate their pregnancies if the foetus was found to be female. (220) These women and their relatives used false names in abortion clinics and lied about the reasons for termination. (220)

3.3.1.4 Fear of consequences of disclosure

The threats used by perpetrator(s) caused or exacerbated migrant women's often overlapping fears about the negative consequences of detection or disclosure of DVA (209), such as fear of retaliation. (202, 205, 209, 213, 217-219, 223, 224) However, many fears were also related to breach of confidentiality – for instance, HCPs informing the husband/family (209, 214, 216, 218), immigration authorities (204, 208, 209, 212, 215, 217, 218, 224, 225, 227), children's services (204, 206, 209, 225, 228) or the police. (203, 204, 208) Fears were also related to the financial consequences of separation and not being able to provide for the children and, partly, becoming homeless. (204, 208, 209, 212, 213, 216, 220, 223, 227) This led some women to fear HCPs even more than the abuser '*as the conduit for unwanted systems' involvement*' ((209) p.84) thus jeopardising *'family solidarity and sanctity*'. ((204) p. 38) These fears held particular power over undocumented, non-English speaking women who due to, for instance, lack of knowledge or because they believed these threats and consequently lived '*beneath the radar*'. (209) However, fears of lack of finances and housing were substantiated as women faced precarious living conditions after separation with lack of access to public assistance. (209, 214, 218, 227)

Related to their perception of violence, many migrant women feared judgement from HCPs (202, 209, 212, 214, 216, 220-223), particularly '*that their experiences would not be validated*'. (202, 209, 212, 214, 216, 220, 222, 223) This also included mental health problems, such as depression, where women feared that they would be told '*anyone goes through that*'. ((221) p. 1135) Some women also feared that there would be no helpful response following disclosure. (228) Moreover, African and Caribbean women did not want to seek help so as not to appear '*weak*'. ((222) p. 164) Some Asian migrant women were worried about seeking '*mainstream*' non-migrant doctors because of '*their ethnic minority status*' ((216) p. 618) and did not expect mainstream HCPs to understand, instead anticipating a suggestion of '*shelter, divorce and welfare*'. ((216) p. 618) Some migrant women also feared breach of confidentiality or judgement from Asian doctors. (214, 216, 218) Consequently, these women faced a double disadvantage:

> *I am afraid to see Asian doctors because they might tell someone or judge me, but the white doctors don't understand my culture, my language – I cannot explain what I am going through or feeling.*
>
> *((214) p.115), Asian woman, UK*

However, women's fears about breach of confidentiality (e.g. (213)) and discrimination were not unfounded, as will be discussed later.

3.3.1.5 Healthcare expectations

Across studies, as said above, many migrant women did not think that DVA, and particularly psychological abuse, could be broached with HCPs. (202, 204, 207, 209, 211, 212, 221-223, 228)

> *Informants did not perceive the need for help because they felt they had found to be either not been exposed to a serious type of IPV or did not believe that health professionals could help.*
>
> *((223) p.200), Saudi Arabian women, UK*

This expectation was strongly shaped by political and cultural factors in their country of origin. Migrant women from diverse countries (e.g. Poland (212), Saudi Arabia (223) and diverse countries (203)) extrapolated their native countries' responses to DVA and expected that institutions in their countries of residence would not respond to DVA either. (204, 212, 213, 223) Some women did not consider their experiences as abuse (204, 209, 211-213, 223, 228) or as sufficiently severe, particularly if they had 'only' experienced psychological abuse. (211, 213, 222, 223) There was also a perception that HCPs would not be interested in their 'private problems' (202, 204, 207, 209, 211, 212, 221-223); for some this was confined to '*listening professionals*' only. (207) This expectation was linked to previous negative experiences. (202, 204, 209, 224) African and Caribbean women perceived healthcare and particularly counselling to be a white domain, some avoiding healthcare as they only expected to receive an unwanted prescription (e.g. for antidepressants). (222)

> *[…] many women were not sure for a long time that they could talk to physicians despite having a regular family physician.*
>
> *((216) p. 620), Asian women, Canada*

These healthcare expectations also influenced what kind of relationship they wanted with their HCPs. (209) These expectations ranged from a '*distant professional relationship to one with a deep personal connection*'. ((209) p. 93) In the Norwegian study some migrant women had hoped that they could rely on their midwives and that the midwives would make them feel safe and provide guidance. (228) These healthcare expectations may be related to the degree of acculturation with more acculturated migrant women only expecting '*straight medical help*' (209), while less acculturated women desired more caring behaviour. (205, 209-211, 217, 222) This was particularly the case if HCPs were women's most long-standing, and sometimes only, external contacts. (209, 228) One African woman saw her GP as '*family*'. (222)

3.3.1.6 Contrained help-receiving due to language and other barriers in healthcare

There were many barriers in the healthcare encounter. Help-seeking and help-receiving was constrained by time constraints, discrimination, language barriers and lack of language provision and inadequate and harmful responses to suspicion or disclosure of DVA by healthcare professionals, including focus on symptoms without investigating DVA.

3.3.1.6.1 Time constraints: 'Your five minutes are up'

Time constraints (207, 221) and HCPs' rushed behaviours were perceived negatively. (209, 210) HCPs were described as carrying out their jobs mechanistically by *'physically rushing, speaking rapidly, failing to make eye contact, focusing on writing while talking, failing to respond to questions, and ignoring the women's expressions of emotions'*. ((209) p. 96)

> *Sit down. How are you? What do you need? Here you go. Goodbye.*
>
> *((209) p. 95), Latina woman, US*

This lack of personal attention was interpreted as lack of caring and taken as a personal affront. This therefore interfered with establishing rapport, trust and full disclosure. (209) Women felt as if they were *'just a number, not even a patient'* ((209) p. 109) and this led many to emotionally disconnect from their HCPs. (209)

3.3.1.6.2 Discrimination

Some women felt not well understood or discriminated against by their HCPs due to language barriers (204, 209-211, 221), racial prejudice (204, 211), immigration status, (204, 206, 210, 211, 214, 216, 219, 221) insurance or payment status. (215, 221)

> *And worse – you don't speak English? They'll ignore you. You're talking to them and they start to talk to someone else in front of you – they make you feel like a dummy.*
>
> *((210) p. 39), Latina woman, US*

One US study reported that English-speaking patients were seen first, even when they arrived later and, moreover, even when HCPs could speak Spanish, they preferred speaking in English, which angered the women. ((211) p. 62) However, it was not discernible whether this discrimination was intended by HCPs. Yet, some women felt guilty for not being able to speak English and so felt that they had to put up with this barrier. (209)

Women also perceived racial and ethnic prejudice; this was described as a '*brusque change from behaving very kindly to giving solely instructions'*. ((204) p. 37)

> *Some of the Latina participants believed that interactions with health care providers were marred by racial and ethnic prejudice. To the extent that these women felt disconnected, disempowered, and mistreated in the medical care setting, they were reluctant to openly discuss their abusive situations.*

((204) p. 37) Latina women, US

Discrimination due to language barriers, lack of immigration status (219), medical insurance status[35] and class (215, 221) affected women's perception of healthcare and left some feeling mistreated. (204, 209, 210) This seemed to contribute to women's perceptions of revictimization in the healthcare system (209-211), which led to disconnection and avoidance of health services. (204, 209, 210)

3.3.1.6.3 Language barriers and lack of adequate language provision

Language barriers and lack of adequate language provision impeded women's abilities to communicate directly with HCPs. (202, 204-215, 218, 219, 221, 223-225, 227, 228) There was a paucity of interpreters (205, 214), they were difficult to obtain (204) and this considerably affected the length of waiting times. (204, 209-211, 219)

> *I don't understand Cantonese or English, so it was very difficult. They had to find someone who speaks Mandarin and I had to wait for a few hours. I waited for at least two hours, a very long time.*
>
> *((204) p. 36-37), Asian woman, US*

Healthcare professionals' attempt to enquire about DVA using screening questions or other questions were often not understood or could be immediately responded to in English. (225) This included open-ended questions such as '*how are things at home*?', which were not understood as an invitation to discuss DVA, but only as a polite question about general health. ((209) p. 148)

When interpreters were used, this often created a distance between the woman and the HCP '*that interfered with creating trust and rapport*'. ((204) p. 37) This inhibited an open discussion about DVA (204, 206, 209, 211), as migrant women lost direct contact with the HCPs. (204, 209) Women were also concerned about confidentiality and how things were translated. (204, 206, 209, 211)

> *Language is a very important factor. It's very important, not because you don't trust what they don't translate, but because when a third person is used, you lose that contact which is very much a part of us, and it puts more distance between the doctor and the patient.*
>
> *((209), p. 37), Latina women, US*

Some migrant women felt that interpreters provided inadequate translation; for example, interpreters did not explain to HCPs what women wanted them to explain, such as change of medication (206), or used inappropriate terminology. (211) Some interpreters were

[35] Some women related insurance status back to their ethnicity.

perceived as *'rushing, insensitive and uncaring'*. (209) All this affected migrant women's trust. (204, 206, 209, 211) Male HCPs and interpreters were found to impede the effectiveness of consultations, specifically in the context of physical examinations or when Latina women had to talk about their bodies. (211) Some Latina women pretended that they had understood what was explained to them when, in fact, they had not. (211) Using interpreters was generally perceived negatively across studies (204, 206, 209, 211), except in one study a quote depicted a woman's satisfaction that her HCP had arranged an interpreter to enable communication. (214)

Bauer and colleagues (204) concluded that

> *'inadequate translation services compromises patient care, interferes with diagnostic power, impairs patient education and, decreases compliance and follow-up, often resulting in patient dissatisfaction'. ((204) p. 39)*

Asian women in the UK could not access or felt uncomfortable accessing counselling due to a lack of language provision and cultural awareness/understanding (e.g. regarding shame. ((214) p. 85)) On the other hand, in one study, Latina women perceived language to be an even greater barrier than culture (209, 221): lack of fluency between provider and patient inhibited open, natural communication and the opportunity for help. ((209) p. 107)

3.3.1.6.4 Inappropriate responses

There were many inappropriate responses to DVA, including focus on symptoms of abuse such as injuries, silence, minimising women's distress, pressuring women to disclose, judgemental advice, breach of confidentiality and harmful signposting.

HCPs frequently focussed on the women's injuries, as well as physical and maternal health problems (202, 205, 206, 209, 214, 221, 222, 228), without investigating the underlying cause. This was particularly evident when migrant women's husbands were present in healthcare consultations. (228) This was often perceived by women as a lack of interest (209) or discomfort or embarrassment on the side of the HCPs, which intensified the women's own discomfort about disclosure (202) and caused them to remain silent (and feeling minimised by suggestion medication only see below). (202, 205-207, 209, 214, 221, 224)

> *Some Latina participants reported encountering providers who focused only on physiological problems and ignored their social and psychological problems. These participants believed that treating only the physical injuries and illness or prescribing sedative and pain medication undermined the patient-provider relationship. This emphasis on medication resulted in some participants losing faith in their providers and contributed to a decreased regard for health care services.*
>
> *((202) p. 310), Latina women, US*

> *I saw the doctor that night, and when he arrived he examined me: 'You're fine, only a little bit agitated. So that you can sleep, here is a little pill to calm you down and a little pill for the pain so that you feel better'. This is lack of professional ethic. I was disappointed. I will never visit a doctor; I better cure myself.*
>
> *((202) p. 310), Latina woman, US*

HCPs' lack of enquiry into DV resulted in many women feeling frustrated, angered, and sad, as they saw these health encounters as '*missed opportunities*' (202, 205-207, 209, 211, 214, 217), which could have reduced their and their children's suffering.

> *The health visitor used to come home for the children, she used to weigh the children and ask me questions about how I am doing. […] But I am just thinking they could have asked, you know about the bruises I had, the state of me. …. one thing I am clear about is that they knew that something was wrong, they knew that something was wrong.*
>
> *((205) p. 163)) Pakistani woman, UK*

Some migrant women wanted to disclose but did not due to their HCPs' behaviour. (206, 209, 214) Other women tried to disclose by dropping hints, yet these hints were rarely understood (209) and often centred on somatic complaints. Women expressed feeling '*stressed*', '*going crazy*', depressed or having '*tensions*'. (206, 209, 214, 221, 222) Some hints were also expressed in a culturally-specific way (209); for example, one Spanish-speaking woman described her partner as having a *'strong character' ('caracter fuerte'),* meaning 'short temper'. (209)

Asian women in the UK received responses which lacked '*understanding of women's experiences, the nature of DV, the causes of their mental health problems and the constraints women live by when subjected to unrelenting control and abuse*'. *((214) p. 82)*

> *My GP said that I should try to relax… go for long walks – I could not even go to the shops without permission.*
>
> *((214) p. 82), Asian woman, UK*

These left women feeling frustrated, low and disconnected as they lacked '*the energy to argue with their HCPs*'. ((214) p. 82) Thus, HCPs' responses caused women to remain silent. (202, 203, 206, 209, 214, 224)

Some migrant women did not receive a proper diagnosis or any information about the prescribed medication (206, 214), which often included multiple antidepressants and/or tranquilisers (206, 209, 214, 221, 226), or their side effects. (206, 214) Not knowing about side effects made it particularly difficult to cope when they occurred, causing anxiety. (206, 214, 215) Some women were also concerned about addiction (214, 215) and together these issues resulted in some women choosing to discontinue their medications. (214) In other cases, medication was abruptly discontinued by the doctor due to women developing

dependency. (214) Migrant women were often unhappy with their medication, as they did not reduce their symptoms (202, 206, 209, 214), especially when they were still experiencing DVA (214) and/or in precarious living conditions. Yet some migrant women sought help only, or primarily, for their physical health problems (214) and requested medication to facilitate sleep or to feel better. (227)

The focus on symptoms seemed exacerbated by the women's lack of language. Prescribing medication without full explanation prevents migrant women from making an informed decision (214) and places them '*in a situation where decisions about their lives seem to be made without reference to their wishes*'. ((214) p. 79) Martinez (206) criticised '*the clinical practice of pathologizing and medicating*' depression caused by violence and multiple oppressions (e.g. social isolation, poverty, poor housing) as this '*could perpetuate and promote oppression by utilizing its power to name and provide treatment to clients*' (p. 102).

This lack of engagement with women's mental health problems also indicates a failure to take the women's experiences seriously (214) and had an enormous impact on women's overall satisfaction with healthcare. (206, 209, 214)

> *At the worst, they indicate collusion with dominant perspectives on domestic violence – that the problem lies in the woman's responses to the violence, and not in the violence itself. Hence the solution centres on modifying her behaviour or response without engaging with causes and without validating her experiences.*
>
> ((214) p. 82) Asian women, UK

Thus, the focus on symptoms, silence or not understanding and minimising women's emotional distress was an inappropriate response. Other HCPs' responses when suspecting or responding to DVA were unhelpful, counterproductive (202, 205, 208, 209, 212, 214, 216, 218, 224) and potentially harmful. (203, 205, 208, 209, 212, 214, 216, 218, 224) Negative HCPs responses included: pressuring women to disclose (209), giving judgemental advice, a lack of follow-up after disclosure, and other unsafe practice (e.g. breach of confidentiality).

When HCPs suspected DVA, women often interpreted their questions as pressure, an '*attempt to break them down*', rather than as a genuine concern. (209) Few women reported screening for DVA ((209, 225, 228), yet when it occurred, it was often done in a rushed and insincere manner (e.g. asking rapidly a few questions) ((209) p. 113), which did not encourage migrant women to disclose violence.

> *'Have you been in a relationship, blah, blah, blah?' Like just a regular conversation, they just don't really go into it. So, you say, 'No, it's fine. I'm okay.' Like just saying hi and bye.*

((209) p. 114) Latina woman, US

For instance, when one Latina woman presented with facial injuries her doctor suspected DV and asked her about it. However, despite liking and trusting him the woman feared that disclosure would lead to her children being taken away. (209) Due to frustration and concern, the doctor then asked a social worker to speak to the woman. This, however, increased the woman's fear even more due to the social worker's 'curt', rushed and pressured manner, which did not elicit trust. (209)

> *[…] I think that what happened was that this person really didn't make me feel, like, safe enough to talk. And she was very curt, very, yes, curt, that's the way I would define it, very curt. 'Look, what happened to you here? There's no problem, everything is going to be fine. Tell me what happened'. [Speaking rapidly, mimicking providers, tapping on table.] And that's it. And I said, no. I'm not going to say anything.*
>
> *((209) p. 120) Latina woman, US*

Here the Latina woman did not seem to be involved in the decision-making regarding a direct referral to see the social worker, which increased her anxiety about her children being taken away. Moreover, the social worker did not appear sufficiently trained to respond to the situation appropriately by pressuring her instead. Similarly, the Norwegian study found that midwives were perceived as powerless after disclosure to screening questions. (228)

> *They appear to be very powerless when they meet a woman who has experienced violence during pregnancy.*
>
> *((228) p. 4) Polish woman, Norway*

Despite displaying information about DV in Spanish in his office, one Latino healthcare provider did not ask about DV. (209) The pregnant Latina woman saw him three times a month for her depression caused by DVA but feared that her children would be taken away if she disclosed.

> *It was always in his room . . . and it was in Spanish. I wanted to say something, but I didn't, because I didn't know what would happen, or what he would say. […]*
>
> *((209) p. 86) Guatemalan woman, US*

The above quote indicates that displaying information alone does not lead to disclosure. This requires a sensitive line of enquiry from the healthcare professional and indicates that the displayed information did not address the woman's fear of consequences of disclosure. The same woman also sought surgery for a tubal ligation but did not continue with it on the husband's insistence. When she told her Latino healthcare professional, he responded laughingly *'Oh, you have a macho man!'* but did not further discuss or explore her relationship with her husband. (209) This suggests that speaking the same language and

being from the same culture does not inevitably lead to an adequate response and requires appropriate training.

Inappropriate HCPs' responses to women's disclosure of DVA included silence (209), *'just leave him'* (209), *'call the police'* (203, 204, 209) or *'why can't you go back to your country?'* (218) or being told that '*the abuser would change at some point'*. ((209) p. 123) Another woman received a conditional offer of help which was depended on her 'improving herself' by getting a passport. (210)

> *[…] she told me: 'You know what? Improve yourself. Get yourself an ID [card] and take some classes. When you've taken care of these things I personally will help you…'*
>
> *((210) p. 34) Latina woman, US*

This indicates that HCPs may lack knowledge about the additional barriers and dependencies encountered by migrant women and that they need more support to leave abusive relationships. This shows that knowledge about DVA must be improved so that HCPs can respond adequately to disclosure.

Unsafe and dangerous practice after disclosure (208, 216, 224) included sending a woman from the Philippines leaflets about DV by post, which were then found by the woman's husband – who threatened her not to disclose to anyone. (224) The GP failed to follow-up, nor did she provide any referrals or information about DV services in subsequent consultations, leading the woman to believe that the GP could not help her; as a result, the woman never disclosed again. (224) Other women felt ignored and minimised, which led to a disconnection with their HCPs and not raising the subject of DV again. (209, 224)

Breach of confidentiality was another inappropriate and dangerous response to disclosure. (208, 216) This was experienced by one Vietnamese woman, where HCPs called the police against her wishes. (208) In another study, one Indian woman disclosed psychological violence to her Indian HCP (216), who then spoke with her husband about this.

> *[…] I asked the doctor can I speak privately [and disclosed her husband's verbal abuse]. The doctor then told my husband that if you tell her off again she will come straight to me. […]*
>
> *((216) p. 618) Asian woman, Canada*

It is not known whether this was requested by the woman. Fortunately, it did not have any negative consequences; however, the potential negative consequences of breach of confidentiality are far greater.

3.3.1.7 Summary of constrained help-seeking and help-receiving

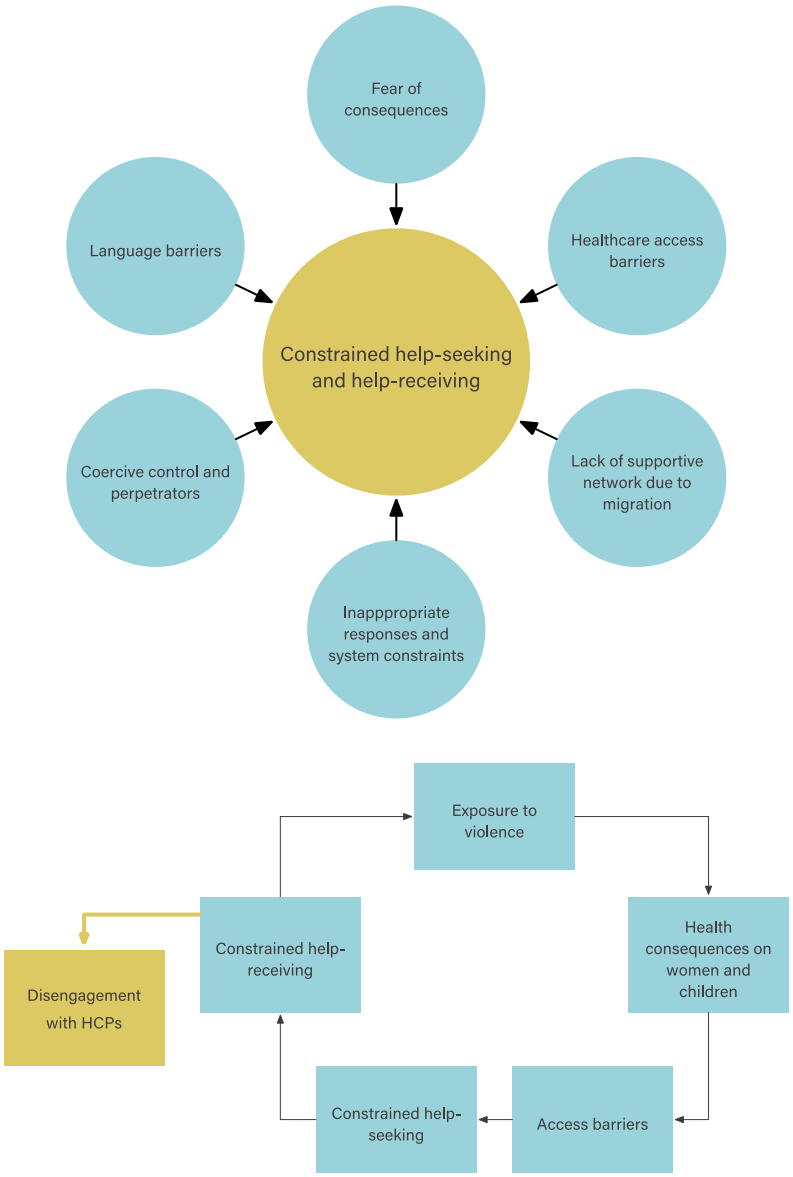
In summary, help-seeking and help-receiving was constrained due to lack of resources, including knowledge and immigration status, feelings of shame and other emotional responses, lack of social support and pressure and coercive control, fear of consequences of disclosure, healthcare expectations, time constraints, discrimination language barriers and lack of adequate language provision, focus on symptoms and inappropriate responses. Figure 3.1 below captures this constrained help-seeking and help-receiving experience in healthcare.

Many barriers were interdependent on each other. For instance, language barriers exacerbated coercive control, social isolation, fear of consequences of disclosure and impeded healthcare access. The greater the number of barriers, the less likely the access to healthcare (e.g. for undocumented women) and the more likely the constrained healthcare experiences. Figure 3.1 depicts the constrained healthcare interactions.

Seventeen publications reported dissatisfaction with the healthcare consultations. (202-211, 214-216, 218-220, 222-224, 228) Kelly stated that this '*often exacerbated the women's sense of disconnection and isolation that was the direct result of the abuse and their immigration experiences*.' ((209) p. 143) According to Kelly, the healthcare encounter often mirrored women's feelings of victimisation and was characterised by '*fear and lack of control and powerlessness*.' (209) This was also due to healthcare professionals' power to set the appointment's agenda, its duration, the treatment and explanations given, as well as (non-)responses to DVA. ((209) p. 107) Consequently, women relinquished control to their HCPs just as to the abusers and remained passive about their own needs.

> *I think my doctors made things worse just by not listening well enough, made things worse, until I was being abused by my husband and my doctor.*
>
> *((209) p. 111) Latina woman, US*

Figure 3.1: Constrained help-seeking and help-receiving



3.3.2. Conditions and triggers for disclosure and pathways to support

The second overarching construct describes the conditions and triggers for disclosure and pathways to support[36], which include violence severity, its impact and trust – all of which I will discuss in the following section. However, as described earlier, even when encountering severe violence, some women did not disclose as fears of consequences were too great – or, when they did, this did not lead to them receiving support.

3.3.2.1 Violence severity and its impact on women and children

Women primarily disclosed when they experienced severe violence, faced increased fear for their and their children's safety, or recognised its health or behavioural impact on themselves or their children. (202, 206, 208-210, 212-214, 216, 217, 221-224)

> *When participants's personal coping abilities were depleted or they "hit rock bottom", disclosures to professionals were triggered as turning points by the severity of abuse and its unbearable consequences for themselves and/or their children.*
>
> *((216) p. 618), Asian women, Canada*

While children were the main reason for many women to stay in abusive relationships (209, 216, 223), they were simultaneously women's greatest impetus to leave when the violence and or its impact became too much. (204, 206, 209, 211-214, 216, 218, 223-225) According to Kelly (209), the mothering role and the children's wellbeing had the greatest influence on women's decision-making process: *'[m]others experienced and managed both the IPV and their healthcare through the lens of their mothering role'*. (p. 291) Children either witnessed violence (224) or were physically involved and affected by it, for instance, when trying to protect their mothers. (209, 212) This violence affected children's emotional health and behaviour (213), causing some to mirror their parents' behaviour, for instance, boys acting like their fathers (209, 212, 213, 216) and daughters like their mothers. (209, 213) This made women realise that they had to disclose and leave. Some children also encouraged migrant women to leave. (214)

> *Women made a risk-benefit analysis, where danger rather than stigma, most strongly influenced their decisions*
>
> *((209) p. 294), Latina women, US*
>
> *Most of the women did seek information and help later in the relationship in the face of increased fear for their own or their children's safety, the realization that their children were being affected by the violence, or during increased emotional and psychological stress. For some women it took years to be ready for this step, and for others this happened earlier.*

[36] The term 'pathways to care' was used in Epstein's study. (213)

((212) p. 74), Polish women, US

The above quote illustrates the time delay in seeking help and disclosing. Some Polish, Asian and Latina women related this point to being 'ready'. (209, 212, 213, 216) The length of time that women endured suffering varied considerably. One study highlighted late help-seeking, yet reported one Asian woman seeking help before reaching crisis point. (216) For this reason, some studies used help-seeking and disclosure synonymously. (212, 216) However, as described earlier, help-seeking did not always lead to disclosure. (217)

Disclosure happened when women '*hit rock bottom*'. ((216) p. 618)(212, 216, 223, 224) Here disclosure was often an *ad hoc* decision when faced with DVA and/or its health impact, seen as a 'turning or crisis point' (212, 213, 216, 224) where disclosure was the only way forward (a '*compelled decision*' (217)).

> *I was extremely emotionally down, there was no other way left to save my life. I went to the psychiatrist.*
>
> *((216) p. 618), Asian woman, Canada*

Women disclosed to unburden, seek emotional support and advice (216, 217, 223), as they could no longer cope with the violence (216), or to document injuries and *'alert authorities to the incidence for future evidence'*. ((223) p. 198) Some women found it easier to disclose to healthcare professionals or other formal agencies to friends and family as GPs were seen '*as a less problematic source of emotional support outside the family than 'going public*''. ((222) p. 300) They sought help in healthcare for their abusive partners (208, 209, 212), including to reverse arrests/court orders, as they felt that their husbands' mental health problem was the cause for the violence. (208) However, as discussed earlier, not all attempts to disclose were understood or responded to appropriately.

Disclosure could also be triggered by a question by the healthcare professional, for instance, about the source of the injury (216, 217, 224, 225), highlighting the need to move beyond treating the injuries to investigating its cause.

> *Most disclosure occurred after a crisis after specific enquiry by a family physician or in the hospital ED.*
>
> *((216) p. 619) Asian women, Canada*

Bystanders (209), the police (208, 209, 214), the children's schools or healthcare professionals (213), court or child protection services (206, 213), community women (216) or community groups could also either disclose or facilitate healthcare access. For instance, in some studies, violated women had to attend mental health services or community groups because of a court mandate and child protection services. (213)

Herminia's head injury was witnessed, and she was unconscious when she was brought to the ED. The cause of her injuries was reported to the emergency department staff by others. She had previously avoided both routine and emergency health care when she had visible injuries, because her husband had threatened to kill her if she went.

((209) p. 89) Latina woman, US

3.3.2.2 Information

Disclosure could also be facilitated by information about DVA and sources of support in healthcare (209, 214, 224, 227), which was partly offered in the women's native language. (209, 227) Information could be provided in form of leaflets (209, 214), posters (224) and talks. (209, 227) For instance, one Asian woman found out about a specialised service for Asian migrant women via a leaflet and then received support from this service. (214) However, from the quote below it is unclear how the woman was referred to the services (self-referral vs referral).

I went into a deep depression and was referred to a counsellor by my GP. At the surgery, I picked up a leaflet about Hosla project. I received support from the South Asian Outreach Worker at Hosla project.

((214) p. 72) Asian woman, UK

Social workers based in healthcare either delivered talks about DVA in community clinics or in English language classes in the women's native language. (209, 227)

They explained what violence was . . . And she said it wasn't okay . . . I didn't tell him where I was going. I didn't tell him that I was going to see the social worker . . . I went to the talks (las platicas) [at the Community Clinic] . . . I said, 'Yes. What he is doing is domestic violence'.

((227) p.33) Latina women, US

The above-mentioned talk in the community clinic was embedded in a wider strategy to address gender-based partner violence and the clinic also offered bilingual and free healthcare services to undocumented Latina migrant women, thus enabling access and disclosure. (227)

However, there was a time delay between receiving information and disclosing DVA. For example, one Latina woman sought help and disclosed violence after hearing a talk one year prior. (209) Another Asian woman in the UK saw a poster and decided to disclose much later after encountering severe violence. (224) While disclosure was not immediate, these findings indicate that information enabled knowledge about DVA and sources of help, which in turn facilitated disclosure and obtaining help. (209, 214, 224, 227) However, as discussed earlier, displaying information on its own was not enough to elicit disclosure and

required a responsive HCP too. From the studies' descriptions, it is unknown whether the provided information also addressed migrant womens' fears of consequences of disclosure.

3.3.2.3 Trust

Trust[37] was an essential prerequisite for disclosure. (202, 204, 207, 209, 213, 228) Although the women's social network was largely found to be unsupportive, there were a few positive exceptions where families, children (214, 216), friends (217) or co-workers (208) facilitated disclosure or disclosed on their behalf. (208, 209)

> *In Sara's case, her English-speaking sister told the HCPs what had happened.*
>
> *((209) p. 89) Latina woman, US*

In healthcare, trust was elicited by person-centred care, consisting of empathy, communication and listening skills (which will be discussed in section 3.3.3), which, in turn, was crucial for disclosure. (202, 204, 207, 209, 213)

Trust often emerged over time (202, 209, 212, 228), but the time required for this varied. While some women needed frequent contact (202, 209, 212), other women only needed one previous contact. (202, 209, 212) This highlights the need for continuity of care. Trust was reciprocal issue: women wanted to trust HCPs, but also wanted to be trusted in by their HCPs. *(*223) This included HCPs trusting the women to know when they were ready to leave. (212) Across studies, trust was closely related to confidentiality and safety. (202, 204, 209, 228)

In my synthesis, Kelly maintained that fear of the consequences was the greatest barrier to disclosure – to conquer this trust was essential. Here, Kelly (209) differentiated between '*interpersonal, professional and practical trust'*. (p.115) The author proposed that migrant women emphasised interpersonal and practical trust, as they trusted HCPs' competence in providing 'strictly medical care'; yet this professional trust was not enough to create a safe context to raise DVA. ((209) p.115) Kelly (209) emphasised the importance of practical trust instead, which referred to being able to disclose DV without fearing that this would result in harmful consequences for the women or their children and proposed a four-needs-disclosure model for Latina women:

> *[t]here were four needs: [1] knowing that their providers cared about them as people; [2] trusting their providers; [3] receiving concrete information about the consequences of*

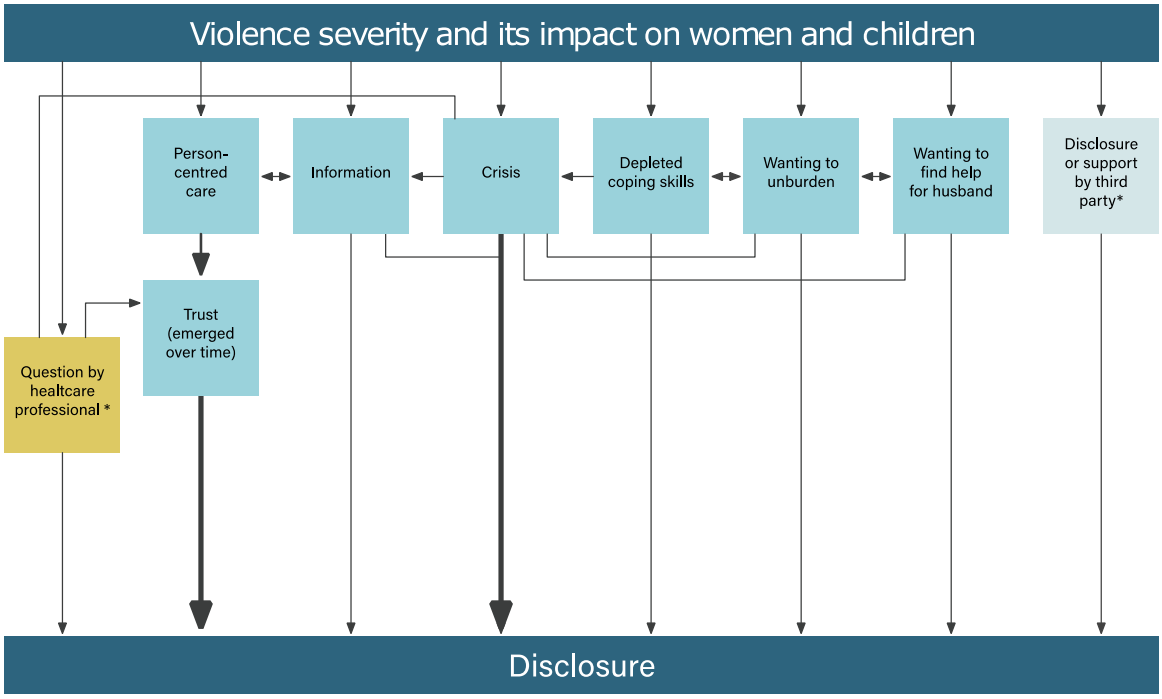
[37] Thus, trust was either explicitly stated as a facilitating factor for disclosure or indirectly (or implicitly) referred to by stating fear of confidentiality, which was by far the greatest obstacle to disclosure, thus precluding or limiting the development of trust.

disclosure prior to any disclosure; [4] and being asked about IPA, either directly or indirectly. If any of these components was missing, in most cases, they did not disclose.

((209) (p. 112))

However, in this synthesis, only few migrant women received information about DVA services prior to disclosure. (202, 212-214) While Kelly's model (209) is important, the severity of violence and/or its health impact may override the four proposed needs. Figure 3.2 below captures the underlying triggers (e.g. severity of violence), information and trust for the decision-making process and disclosure and pathways to healthcare. It should be noted that the conditions for disclosure may overlap (e.g. disclosure triggered by violence and facilitated by trust).

Figure 3.2: Conditions and triggers for disclosure of DVA



Key: Bold arrows indicate the main trigger or condition for disclosure.
The asterisk indicates that in some cases there was language provision which made disclosure possible (e.g. due to the HCP speaking the language, the use of an interpreter or a family member interpreting and disclosing the abuse).

3.3.2.4 Pathways to support

Few studies (209, 213, 214, 224, 227) examined the exact pathways to healthcare or help and most did this sporadically for individual women (e.g. (209, 214, 216, 224)). As previously mentioned, some women directly disclosed in healthcare while others did this via a third party, who disclosed on their behalf or referred them to healthcare. While most migrant women in the synthesis had consulted healthcare services because of DVA, it was seldom identified or disclosed in healthcare; thus, support was found in DVA organisations

via the police, court order or community women. I will now discuss to the importance of person-centred care.

3.3.3 Person-centred care experienced and needed

Person-centred care [38] is the third overarching construct and is (i) a condition for disclosure, as it elicits trust (202, 207, 208, 213, 214, 216, 222, 228), (ii) and/or a positive response to disclosure (202, 208, 209, 213, 214, 216, 222) or (iii) an unmet need of migrant women. (202, 204, 206, 207, 209-211, 213, 214, 216, 222) It consists of showing care and concern, and providing support and (cultural) understanding; communication and listening skills, including asking sensitively about DVA as the underlying reason for seeking healthcare; offering information and advice; referrals; adequate language provision, continuity of care and respecting women's need for autonomy and safety.

> *Participants described several provider-related factors that facilitated [...] communication with their providers about domestic violence, including open and supportive patient-provider relationships, encouragement by providers to discuss abuse issues, and continuity of care. Latina women often used the Spanish term confianza[39] to describe the constellation of trust, confidentiality, support, comfort, and safety that was essential for facilitating discussions about domestic violence. Listening attentively, offering advice and support, and providing referrals were all identified as ways providers can create personal relationships and a supportive atmosphere. [...]*
>
> *((202) p. 310), Latina and Asian women, US*

3.3.3.1 Showing care and concern

Showing care and concern and thus providing emotional 'support' was found to be highly important across studies. (208, 209, 211-214, 223) Again, it could be both a facilitator of (202, 208, 213) and a response to disclosure. (208, 214, 222) This may, as above, be described as a '*supportive patient-provider relationship*' (202) consisting of empathy and being understanding. (208) For Latina and Asian migrant women, a *'compassionate and supportive'* context was central to facilitating communication about DVA. (202) In contrast to the Latina women's above *confianza*, Asian women were anxious about DV as they feared that their experiences would not deserve the HCPs' attention. (202) These women desired a *'kind-hearted'* and *'concerned and caring approach' 'that demonstrated an understanding of DV'*. ((202) p. 310) These desired attributes were also found in other studies. (207-210, 216, 218) This overlap shows that the boundaries between showing care, compassion, emotional support, and understanding were not clearly demarcated. (202, 208) This is conveyed below.

[38] Person-centred and patient-centred care will be used synonymously.
[39] *Confianza* means trust in Spanish.

> *[…] For many abused Vietnamese American women who desired to escape abuse but faced pressures to conform to Vietnamese family traditions, the understanding and empathy of Vietnamese American caseworkers were valuable sources of emotional support.*
>
> *((208) p. 222– 223), Vietnamese women, US*
>
> *[…] There were many Vietnamese working there, and I could talk with them in my language. They listened to me; they understood my situation…They did not criticize me for not seeking help because they knew what was happening in many Vietnamese families like mine; they gave me lots of emotional support.*
>
> *((208) p. 223), Vietnamese woman, US*

In the interaction between the Vietnamese woman and health laypersons, the following elements can be distilled: talking in one's own language, listening to the woman nonjudgmentally and not criticising the woman for staying by showing understanding of what goes on in Vietnamese families and providing emotional support. Thus, the support and understanding could be (i) linguistic/cultural (208, 214, 216), (ii) and/or gendered (207, 214) or (iii) specific to DVA. (202, 205)

Ahmad and colleagues (216) showed that the characteristics migrant women most sought in HCPs were *'high trust, non-judgemental attitude (friendly listener) and cross-cultural understanding'* (p. 618) , as shown in the following quote, which, however, also highlights the attention and time:

> *He [family doctor] spoke to me a lot about my children, about my husband, about the culture, and told me about differences in cultures and not to worry. He gave me attention and a lot of time.*
>
> *((216) p. 618), Asian woman, Canada*

However, when authors concluded that this understanding was cultural, the cultural specificity could not always be extracted from the quotes, which may be due to lack of space in journal articles. The underlying understanding encountered or desired by migrant women may represent a person-centred care approach; that is, being non-judgemental and understanding by showing care, empathy, kindness and providing emotional support. This includes specific understanding of DVA (202) or cultural understanding of the pressures faced by migrant women affected by DVA (208, 214), or all of these elements. It remains unclear what kind of understanding is desired by migrant women affected by DVA and whether this may be more universal and less connected to culture.

Some women reacted to HCPs (including male professionals) from the same country (e.g. India, Saudi Arabia and Vietnam) positively (208, 216, 218, 223); however, as mentioned earlier, there was one case where an Asian doctor breached confidentiality (216) and it was unclear whether the woman had consented to this. It should be noted that even when

consented by women, this kind of breach of confidentiality may be extremely harmful.Yet, as reported earlier, healthcare professionals from the same country/culture did not always identify symptoms or responded appropriately (209); hence some women encountered a double disadvantage by fearing judgement and/or breach of confidentiality from these HCPs, while simultaneously not feeling understood by mainstream non-migrant HCPs due to lack of cultural knowledge. (214, 216)

3.3.3.2 Communication and listening skills

I will now examine the qualities which make migrant women perceive HCPs as caring.

3.3.3.2.1 Showing interest

Women perceived healthcare professionals as caring when these professionals showed interest in them as persons, for instance, by asking women about their children. (202, 207, 209, 210) This was essential for developing (interpersonal) trust (202, 204, 207, 209, 210):

> *The most commonly described means of demonstrating caring and concern was to talk with women on a personal level. The women urged HCPs to talk with their patients, '"platicar",[40] to have conversations that are personal and social in nature, before asking medical questions.*
>
> *((209) p. 114), Latina women, US*

Showing care also involved healthcare professionals displaying congruent non-verbal behaviour. Women closely observed healthcare professionals' tone of voice, body language, mannerism and eye contact to assess their trustworthiness. (202, 206, 207, 209) Caring and concern were inferred when healthcare professionals showed '*a kind and friendly affective manner, which was not brusque*'. ((209) p. 114) This again emphasises the importance of time and being attentive in building trust.

> *The women who participated in this study gave very detailed information regarding what creates confianza (trust) in a doctor or nurse. […] Sincere acts of presence, such as a smile, a question that demonstrates interest in her as a person and listening to her are very likely to determine how much she is comfortable revealing.*
>
> *((207) p. 735), Latina women, US*

Thus, what may be perceived as 'social chat' to create rapport and trust may be crucial for disclosure of DVA. This might be particularly important for migrant women who were often socially isolated because of migration, feelings of fear and shame. Language barriers made this even more difficult. Some studies reported that healthcare professionals were women's only and longest standing outside contacts. (205, 209, 222, 228) As mentioned earlier, some women even saw healthcare professionals as 'family'. (222) To overcome language

[40] *Platicar* means to talk in Spanish.

barriers, it is very likely that migrant women who cannot speak the language may pay more attention to HCPs non-verbal behaviour. Moreover, these clinical encounters with migrant women may need to be allocated more time to allow the HCPs to listen to women's answers carefully and to allow for professional interpreting.

3.3.3.2.2 Asking about DVA

Some HCPs tried to find out the cause for the health problems by questioning or encouraging migrant women to talk about DVA. (202, 204, 209, 211, 214, 216-218, 221, 222, 224) This also enabled some women to make the link between their mental or physical health and DVA. (214, 221, 223)

> *Every time I went to the doctor it was the same doctor, so we became familiar. Could it be that I was that clumsy to fall all the time? So the second time I saw the doctor, he asked me. We knew each other better so I wasn't scared or shy anymore, and I didn't know what else to do, so I told him.*
>
> *((202) p. 310), Asian woman, US*

This quote highlights again the importance of continuity of care (see 3.3.2.3.1 time and continuity of care), as repeated encounters allowed for rapport and trust to develop (202, 204, 207, 209, 213), which was found to be important across studies.

> *[…] I felt comfortable because he saw that the problem wasn't that [I was ill]. He said, 'a problem, tell me'.*
>
> *((202) p. 310), Latina woman, US*

Shirke and colleagues (218) defined this as being caring enough '*to go the extra distance involved in finding out what their needs were and how they could help*'. (p.18) In their study, an Asian Bengali-speaking hospital consultant was concerned about how thin an Asian woman was and insisted that the woman's husband would leave the room so that he could speak to the woman on his own (by pushing the husband out of the door). When the consultant ascertained DV, he initiated help and referral by contacting the police. (218) However, it is not known whether informing the police was a shared decision nor how professionals without these language skills would have managed this situation. Involving an interpreter might have interfered with building rapport and trust (202, 204-206), yet the woman might have disclosed nevertheless due to the severity of her desperation.

Wanting to be asked or encouraged to talk about DV was an unmet need identified across numerous studies. (202, 205, 207, 209-211, 216, 218, 225, 228)

> *Both Latina and Asian participants expressed a desire for providers to initiate discussions about domestic abuse. Several participants discussed the difficulty of disclosing abuse and asking for help, particularly in situations where providers did not ask directly.*

((202) p. 310) Asian and Latina women, US

'Wanting to be asked' was a strong need as women felt it too difficult to raise it on their own. However, women often also simultaneously feared disclosure. In Kelly's study (209), Latina women wanted to '*relinquish control to their HCPs*' by adopting an '*if you ask me, I will tell you'* stance. ((209) p. 89) Healthcare professionals were perceived as being important in raising awareness about DV by '*opening women's eyes*'. (207, 209, 213, 223)

Some authors interpreted this need for being asked as support for screening or routine enquiry. (207, 209, 214, 216) While the need for being asked was generally supported by first-order constructs (202, 205, 207, 209-211, 216, 218, 228), some studies did not give first-order constructs or they deviated from the authors interpretations. (207, 216) For instance, Ahmad and colleagues maintained that *[w]hen asked, to comment whether physicians should routinely inquire about partner abuse, all women unanimously agreed.* ((216) p. 619) Yet, their corresponding first-order construct (see below) indicates support for enquiry about DVA only when healthcare professionals suspect abuse. (216)

> *Everyone here is telling you more or less that they spoke to the doctors, I think that doctors should be part of the circle that if they get a clue that a lady is going to be abused he should double-check or confirm. The doctors should be part of the system to check for woman abuse.*
>
> *((216) p. 619) Asian woman, Canada*

Few studies investigated how DV should be raised – i.e. whether women preferred direct or indirect questions about it. (202, 207, 209) Migrant women wanted HCPs to notice symptoms of DV and to sensitively initiate a conversation about DV. (202, 205, 207, 209-211, 216, 218) Moreover, while some women preferred that DV should be raised directly (202, 228), others preferred indirect questions. (207, 209) Women's preference may depend on the context, duration and quality of their relationships with their HCPs with length being related to preferring direct questions. (202)

> *…For me, it's best directly, actually. Because if someone starts to ask around it, I'll answer, but then I think, 'what is she really getting at with all this?'*
>
> *((228) p. 4) Polish woman, Norway*

However, a more indirect approach over time seemed to be preferred by other women, who desired a subtle, '*non-aggressive*' way by asking the women, for instance, whether they were doing any activities outside the house apart from looking after their children (207, 209, 210), as this may elicit answers indicative of DVA. ((207) p. 734) However, as described earlier, language barriers may interfere with subtle probing. Instead of using '*how are things at home?*' Latina women found *'how's your marriage?'* much more

appropriate to find out about DVA. ((209), p. 116-117) Another need was linked to providing information about DVA and reasons why healthcare professionals needed to ask or to ask openly about women's understanding of violence first. (228)

> *…Maybe women need more information about what violence is? I didn't know that physically and psychologically violence are two different things. (…) I thought that violence means to beat, really beat. Not only once or twice.*
>
> *((228) p. 4), Turkish migrant woman, Norway*

This Norwegian study found that communicating with the midwife about IPV was perceived as more appropriate toward the end of pregnancy, as at the start women felt often overwhelmed with information and needed time to build trust. (228) Enquiry had to occur in private, without the husband being present. (228)

The healthcare setting may affect screening, enquiry about DVA and disclosure. One UK study found that most proactive DV screening was carried out in the obstetric setting, when compared with general practices. (214) In this study, women's satisfaction with their health visitors' or midwives' responses was greater when compared with their GPs'. ((214) p. 103), which was partly echoed by an US study on Latina women. (209)Women may feel closer towards their midwife as pregnancy presents a unique opportunity to establish trust over multiple visits, which enables communication about DVA. (228, 230) This again shows how important continuity of care is as trust develops over time.

3.3.3.2.3 Listening skills

Across studies, listening skills were found to be central. (202, 206, 207, 209, 216, 217, 221) HCPs' listening skills could act as a facilitator to talk about DVA (207, 209, 216, 217): '*a willingness to listen may increase openness to disclosure' (*(217) p. 356), which was echoed by other studies. (e.g. (207, 209, 216)) Being able to listen again requires time.

> *I think it is best that the doctor tries to listen. To listen. Because many times although they ask questions and you answer, you are not able to tell them well because the doctors never have time to listen.*
>
> *((207) p. 733), Latin woman, US*

Listening was equally important after disclosure (209, 213, 216, 217, 221, 223) where it was perceived *'as a complete response'* and included *'staying with the women during silent pauses'*. ((209) p. 118-119) Listening encompassed observing non-verbal behaviour and responding appropriately too. (202, 204, 209)

> *The women described the importance of listening in the full sense of the word, to responses as well as silences, to verbal and non-verbal reactions. Many felt that attentive HCPs could detect as much by a woman's silence as by her words. […]*

((209) p. 118-119), Latina women, US

Many women wanted to be listened to (202, 206, 207, 209, 216, 217, 219, 221-223) and allowed to communicate their feelings about abuse (223) – '*to talk to someone for validation purposes without being told what actions they should take*'. (p. 365-366 (217)) This required a non-judgemental listener. (208, 209, 216, 222, 223) Ahmad and colleagues' (216) earlier description of a '*non-judgmental attitude (friendly listener)*' indicates a desirable combination between having a non-judgemental attitude (attribute) and listening (behaviour) in a friendly manner (e.g. expressed by smiling). This non-judgemental aspect of listening stands in direct contrast to the judgemental advice feared or experienced by women, as described earlier. (209, 210, 218)

[…] That was all that I wanted, only that someone would listen to me.

((213) p. 45), Latin woman, US

Being able to talk and being listened to non-judgementally was experienced positively. (202, 206, 209, 216, 218, 221, 223) It reduced isolation (213, 219), opened the women's eyes that they were affected by DVA (207, 209, 213, 223) and validated women's feelings. (202, 217) The listening could also happen in the context of, for example, self-support groups or counselling. (202, 217, 219) Given that migrant women often faced additional pressure by their families to stay with the abuser, this may be the only chance for women to 'unburden' (217) and have their feelings and situations validated.

3.3.3.2.4 Linguistic and cultural congruence

Speaking the women's native language could facilitate raising DVA. (208, 209, 218) Consequently, some authors suggested linguistic and/or cultural congruent HCPs (206, 208-210, 214, 216) to overcome language and cultural barriers. However, as stated earlier, HCPs from the same country/culture who spoke the women's language did not guarantee that DV would be identified or addressed (209) and they were, in some cases, also a source of fear. (214, 216) For some Latina women, it was not crucial for HCPs to be from the same country or speak the same language. (206, 209, 221) Some Latina women were even willing to put up with non-proficient HCPs because of personal liking. (209) Kelly concluded:

Very few of the women identified cultural bias by non-Latino providers as an influence on their experiences of health care. Language barriers were more important, and more of an obstacle to understanding and communication. However, more important than cultural or linguistic congruency was a sense of connection with their HCPs, and a feeling that their providers were compassionate and caring.

((209) p. 107), Latina women, US

This seems to confirm the importance of person-centred care. Nonetheless, language provision is important for accessing healthcare, particularly mental healthcare. (214) In one UK study, Asian women could not access counselling due to lack of language provision and cultural understanding. (214) Some authors suggested improving access to female interpreters (211); however, as outlined earlier, communicating via interpreters could also pose a barrier. One US study revealed that Latina women wanted to communicate directly with their therapists and not via an interpreter. (206, 214) Whether (or not) migrant women prefer talking to someone in their native language (and from the same culture) may depend on the healthcare setting and their personal preference.

3.3.3.2.5 Gender congruence

Some authors inferred that women preferred female HCPs (207, 211, 214, 216) and that gender congruence was associated with trust and confidence (207, 214), feelings of safety (214) and understanding regarding DV (214), yet not all found this. (225)

> *I would like to talk with a woman doctor because she gives you more confidence to tell her your problems. If I go to a (woman) doctor that had a good personality, I would feel free to pour my problems out to her.*
>
> *((207), p. 732), Latina women, US*

Some migrant women feared that male HCPs who were not from the same country and culture '*would collude with dominating perspectives*'. (216) In one study, migrant women felt uncomfortable being seen by a male HCP (or needing to use a male interpreter), particularly in the context of a physical examination. (211) The need for gender-congruent HCPs may be related to the women's degree of acculturation, with higher acculturated women potentially showing more openness towards male HCPs and being more comfortable with physical examinations. (211)

Where a preference for female HCPs was proposed by authors (207, 211, 214, 216), this did not always correspond with their first-order constructs (e.g. (216)). Diverse migrant women disclosed to male HCPs (224), including HCPs from India, Bangladesh and Saudi Arabia, who they described as helpful (216, 218, 223), caring and attentive listeners. (202, 213, 214, 216) In contrast, some female HCPs responded inappropriately. (209, 210, 224) Thus, the HCPs characteristics *(e.g. '[h]e listened to me as if he were my brother',* ((202) p. 310)(207, 221)) may be more important – than perhaps the HCP's gender *per se*. However, some (migrant) women might still prefer female HCPs (and interpreters), particularly in the context of a physical examination. (210) The issue of whether (or not) migrant women prefer a female HCP, may therefore be simply resolved by asking the women. (211)

3.3.3.3 Information and advice

As mentioned earlier, some migrant women desired information about DVA, its effects on children, sources of help and safety strategies before disclosure – some women preferred this information to be given anonymously in groups, in form of cards, leaflets or films in healthcare. (228) Information was also crucial in response to disclosure. Migrant women were satisfied with or desired information about available DVA services in the community (203, 212, 214, 216, 227), including free healthcare and support groups (210, 211, 227), as well as information on the impact of violence on their own or their children's mental and physical health. (214, 221, 228) Women also required general information about healthcare (209, 215) and laws against DV. (212, 223, 228)

> *During my second pregnancy, when I used to go for my monthly check-ups, I told my midwife a little bit about my situation. She was sympathetic, she gave me emergency contact numbers. I was happy with the advice and help I got from her. After I gave birth to my baby, I decided to leave home. I told my health visitor everything and she contacted the social services [...].*
>
> *((214) p. 103) Asian woman, UK*

The above quote shows that this Asian woman received advice and information about emergency services on disclosing to her midwife. While the Asian woman appreciated this signposting, it was not immediately followed up – echoing the previous discussion in section 3.3.2.2. This time delay between receiving information and following it up has also been found in other studies. (209, 212-214)

> *Women enduring domestic violence are seldom able to follow advice from service providers to leave the abusive relationship immediately.*
>
> *((214) p. 103), Asian women, UK*

The above suggests that signposting may be inadequate, as particularly migrant women may need more support, in the form of direct referrals, when facing severe coercive control, language barriers and lack of resources for accessing services (e.g. no or limited telephone access and lack of transport).

Some women appreciated being asked and wanted to know more about the mental and physical impact of violence on their own and their children's health. (221) One study on Hispanic migrant women affected by DVA in the US found that these women needed to know what was wrong to get better and to better manage their lives. (221) These women were grateful when they were explained that their physical symptoms were caused by depression, which stemmed from their experiences of violence. (221) Some women believed that this knowledge would have motivated them to disclose earlier. (228)

> *…If I would have known what could happen to the baby when the mother is stressed and impatient, and that it's not only things you eat that influences the health of your child… I think I would have talked about it earlier.*
>
> *((228) p.5), Polish migrant woman, Norway*

It was also found that some women – particularly in rural areas – needed information that could be given anonymously as they were concerned about privacy or taking the information home. (228) While one Canadian study on Asian migrant women suggested information could be offered on the internet (216), the Norwegian study pointed out that accessing this information posed a problem as husbands often checked women's search histories. (228) Similarly, while some Asian women in Canada desired information through the media, others feared that this would lead to more violence at home. (216)

3.3.3.4 Need for autonomy and safety

While many women were desperate for a listening ear, information and advice, including about how to keep safe (228), they did not want HCPs to take any action, nor did they expect HCPs to find solutions for their situations (202, 223) or wanted to be pressured into action (e.g. 'just leave him'). (209) Women wanted to preserve their autonomy (217, 223) and remain in charge of what and when steps were going to be taken. This was often explained by their fear of the consequences (e.g. (204, 209, 212, 214, 216, 223)) and of leaving. (212) Konczak (212), therefore, concluded that HCPs should trust women's own assessment of danger and allow them to decide when they were ready to leave. Yet many of these Polish women had prepared steps to escape violence (e.g. packed bags, sleeping in the car).

> *[…] HCPs can just plant the seed, and know that they cannot fix the problem, they can only offer help and support.*
>
> *((209) p. 122), Latina women, US*

It was unclear whether (or not) migrant women expected police involvement (208, 209, 218, 224); in fact, some were opposed to this (208) as it would '*infringe on patient-physician confidentiality and autonomy*' alongside trust and safety, without which DV would be difficult to disclose ((202) p. 340). Thus, these migrant women wanted to retain control over decisions about when to involve the police. (203)

> *[…] abused women in our study felt that physician reporting to police potentially jeopardizes the safety of patients, deters abused women from seeking medical services, and compromises medical professional standards of confidentiality and patient autonomy.*
>
> *((203) p. 340), Latina and Asian women (alongside non-migrant women), US*

However, other women both feared the involvement of police by HCPs, while (203, 209) they also wished for it as this would relieve them of the burden and responsibility of making a report. ((203) p. 339)

> *[…] I didn't want to be the one calling the police. I wanted somebody else to see the situation that I was living and for them to call the police.*
>
> *((209) p. 91), Latina woman, US*

One Latina woman used nurses as a means of protection: she told her partner that the nurses would be looking out for her and visiting her at home, which stopped her partner from being physically abusive. (209)

In one UK study, reported earlier, it was unclear whether a Bengali-speaking woman had been involved in deciding whether her consultant should call the police. However, for this woman, involving the police may have been the only option to ensure her safety and well-being, as she suffered from extreme coercive control and neglect (including being denied food and imprisoned) and could not speak English.

Consequently, this may pose a dilemma for HCPs in deciding between a migrant woman's right to autonomy versus perhaps her desire that HCPs should take charge and, also, a predicament for HCPs wishing to respect (migrant) women's choices and to safeguard them (and their children). Shared decision-making and careful weighing up of the risks are crucial. Bauer and colleagues (204) recommend HCPs to maintain independence from law enforcement agencies. However, mandatory reporting may restrict this considerably for HCPs. (204)

3.3.3.5 Referrals

Migrant women were found to be satisfied when HCPs referred them to counselling or other mental health services (202, 214, 221, 222, 227), including self-support groups (212, 213, 219) – provided that DVA was addressed here. Specific benefits of psychotherapy, counselling or self-support groups included: a feeling of relief through sharing about IPV and issues deemed otherwise too embarrassing (211, 214, 221); overcoming stigma (211); feeling enabled to help better oneself (e.g. avoiding shelters and finding better work (221); developing strategies to deal with DVA without having to leave the abusive relationship (222) ; increased self-esteem (213, 221); and social support. (213, 219) Support groups were perceived as a respite where women could safely vent (213), while others described being listened to as a cure for their depression, brought about by suppression of violent and stressful experiences. ((221) p. 1135)

So I feel good with my counselor because I tell him everything; I open up, and I feel relief. So when I tell him my stuff I feel relief and depression goes away.

((221) p. 1135), Latina woman, US

This was particularly beneficial for migrant women who were extremely isolated following migration and language barriers – these groups enabled them to form new contacts and provided sources of support, including knowledge, which many women lacked. Receiving support to deal with DVA without having to leave the relationship may, thus, be an alternative to extreme ostracisation and lack of access to public funds due to immigration status.

Migrant women also appreciated the counsellors' neutrality (222, 223) and the confidential nature of the counselling ((222) p. 265) and support groups. (211, 213) While self-support groups were found to be beneficial, some women desired additional individual therapy (211), which may be related to confidentiality concerns, shame and not feeling comfortable voicing private issues among others.

When receiving mental healthcare, some women required more sessions (214), more closely spaced (211) (i.e. not every 14 days), with the same HCP. (211) However, some women encountered abrupt cessations of their therapies due to staff turnover (206, 211, 214) and they often had to re-tell their stories to a new therapist. (206) This represented a significant barrier and highlights again the importance of continuity of care.

I felt much better that I had someone who was listening to me. I saw her 4-5 times, then she left. […] I would have liked to see the counsellor for longer as that was helping me. ((214) p. 86)) Asian woman, UK

3.3.3.6 Wider needs

Migrant women had multiple needs related to separation, particularly when they were undocumented or lacked an independent immigration status and did not have access to public funds. (214, 218) These included navigating the judicial system to obtain independent residency status (227), divorce (227), finding shelter or adequate housing (214, 227), learning the language (206, 208), finding a job (227), childcare (214, 221) and establishing a new social network. (216) Many of these needs were interdependent; for instance, obtaining an immigration status was required to obtain work and housing. (227) Thus, as Parson (227) and colleagues concluded for undocumented Latinas,

'integrated social service response emerge as key health care responses. Clinicians should be awareof the multiple barriers to treatment for these women and improved outreach strategies should be developed. Increased collaboration among various community agencies including schools, community mental health agencies, hospitals, and law enforcement is also imperative to help connect Latina immigrant women with the services they so desperately need.'

((227) p. 34) Latina women, US

Few women experienced these integrated responses. The study by Parson and colleagues (227) offered undocumented Latin women free, bilingual social and legal support and mental healthcare. This was delivered jointly by social workers and healthcare professionals. The social workers supported these women in navigating the judicial system, helped with housing, further education and referred them to mental health clinics. (227)

> *I've been going to the clinic almost since it opened. There I went to the doctor when I was pregnant with my daughter . . . And I started seeing the social worker more, and that was when she realized that he was hitting me . . . Whatever I need, I go. I look for her. I'm going to go show her my diploma (GED) . . . One day, when the law changes, I'll get my papers, and then I'll get a better job . .*
>
> *((227) p. 33) Latina woman, US*

This highlights the importance of interagency working to support the complex needs of abused migrant women (227) and their children. Some women reported that children had been taken away from them due to DVA or its impact on their mental health, including unsuccessful suicide attempts, for which they felt penalised. (206, 209) This greatly impeded any improvement in their mental health. Moreover, another issue caused by DVA was found to be women's own violence towards their children or daughters-in-law experiencing DVA. (222)

> *[...] displacement of anger against their children with abusive behavior by repetition of the trauma, admitting that the smaller the child, the more victimized they were likely to become*
>
> *((211) p. 51) Latina women, US*

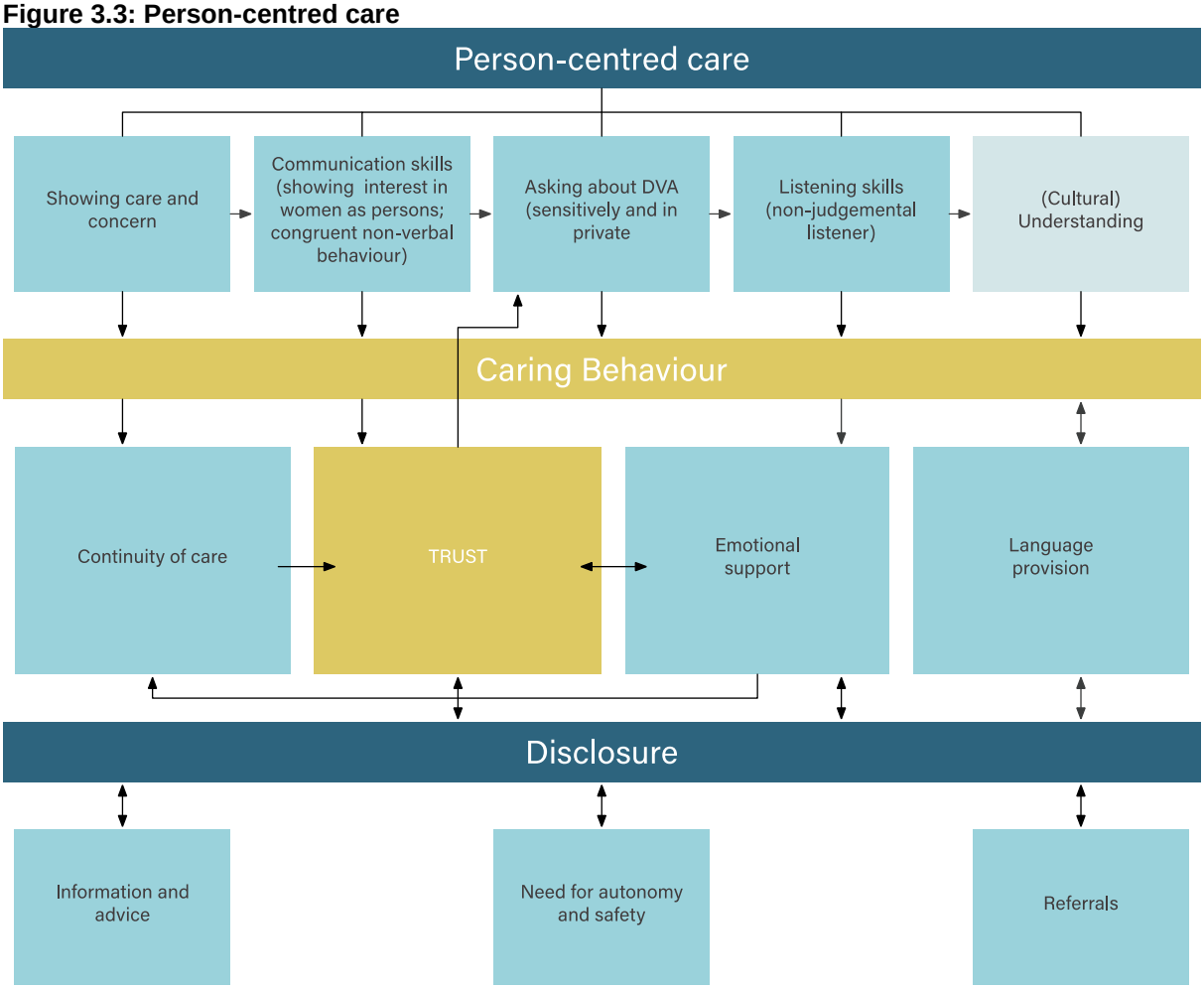
Similarly, one woman did not support her abused daughter-in-law and instead pressured her into staying.

> *[Queisha recounts how she told her abused 'daughter-in-law']..'You know, it's a 50:50 thing...I can't tell you to leave him...the children are going to need both of you... you know you're not the only one, you've accepted that so it's now how you're going to manage that!'*
>
> *((222) p. 162)) Carribbean woman, UK*

Thus, in both cases, victims may themselves become perpetrators, leading to repetition of violence, trauma and lack of support. Appropriate interventions are needed to address women's own victimisation.

Some publications reported person-centred care by HCPs, which helped migrant women (202, 208, 209, 213, 214, 216, 218, 221, 227)); however, this could refer to a single woman in the study (e.g.(209)), many other publications did not and here migrant women desired it. (202, 205-207, 209) Figure 3.3 below conceptualises person-centred care.

Figure 3.3: Person-centred care



3.3.4 Line-of-argument synthesis

In the following, I will present my line-of-argument synthesis. By bringing my three overarching constructs together, I will give an overall conceptual account of migrant women's healthcare experiences, pathways and needs.

As the studies' foci differed, they varyingly investigated migrant women's healthcare. The Noblit and Hare (155) 'lines-of-argument' synthesis involves constructing an interpretation, to make visible what may be hidden in individual studies to discern a whole among a set of parts ((158) p. 680). As researchers often examine '*different aspects of phenomena [...] arranging the studies' metaphors in some order [might] allow us to construct an argument about what the set of ethnographies say*'. ((199), p. 1349 (161)) Hence, the 'line-of-argument' approach was appropriate to synthesise migrant women's healthcare experiences, while also using temporal order.

Constrained help-seeking and help-receiving described various often interrelated and mutually reinforcing barriers while accessing and within healthcare (e.g. lack of

immigration status and language barriers). (209) Migrant women who accessed healthcare seldom disclosed DVA because of coercive control, fear of consequences (e.g. deportation, loss of children), not seeing DVA as violence or a valid matter which could be raised in healthcare and feelings of shame. Healthcare consultations were often affected by time constraints, language barriers and lack of language provision; moreover, certain healthcare professionals only focused on symptoms without investigating the cause. Migrant women also encountered discrimination in healthcare, reporting inadequate and potentially harmful responses. This constrained help-seeking and help-receiving is conceptualised in Figure 3.1.

Disclosure was primarily triggered by a crisis when women were faced with (severe) violence, impacting them and/or their children. Here, disclosure was a compelled decision. Trust was another precondition for disclosure – yet this prerequisite could be overridden by crisis. Healthcare professionals could elicit trust by providing person-centred care, which included giving information and adequate language provision. However, the severity of violence and trust did not always lead to disclosure, as the fear of consequences from the women's side were greater. At times, a third party disclosed on a woman's behalf, or the social network or other organisations acted as pathways to healthcare/help. This was visualised in Figure 3.2.

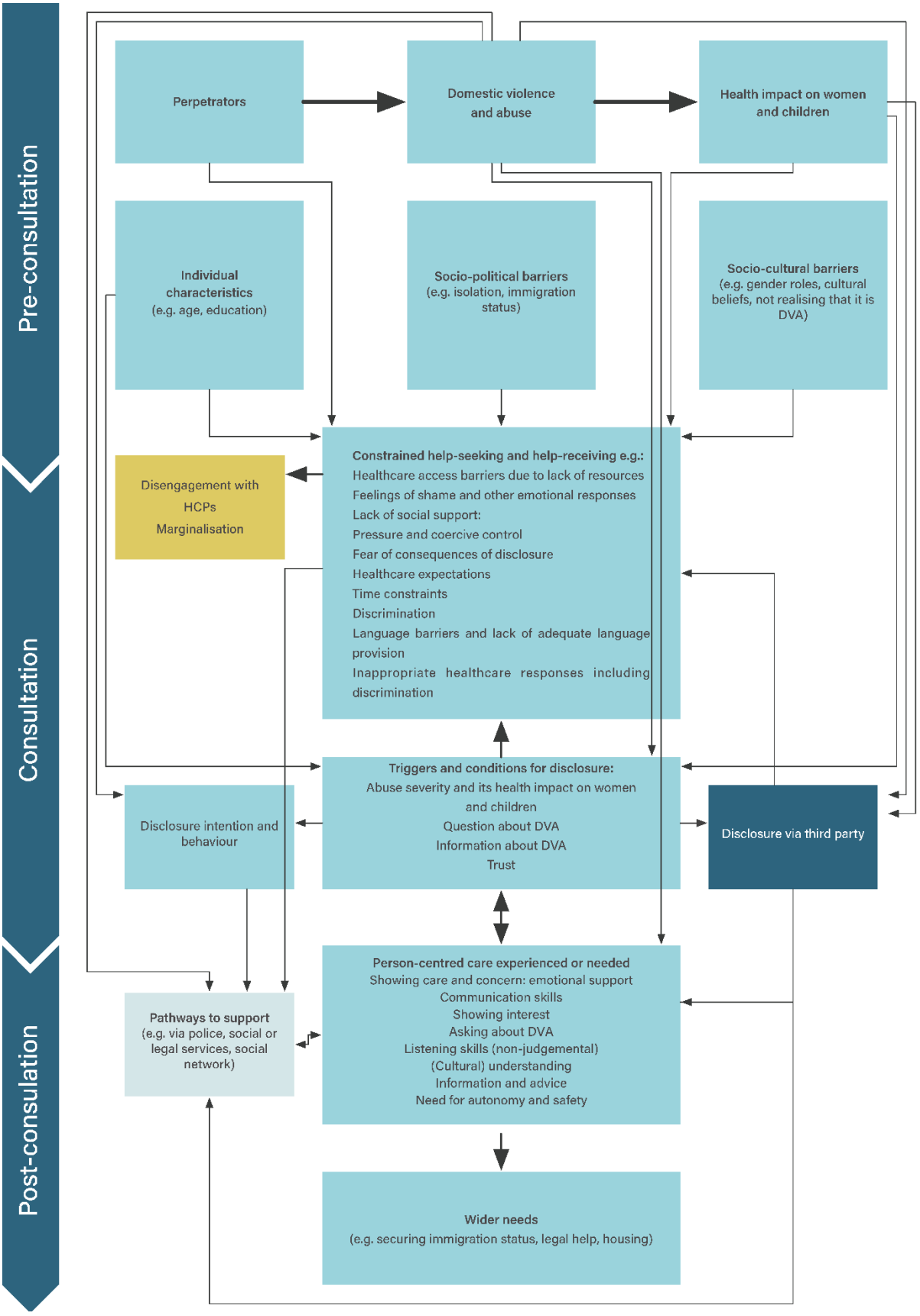
Person-centred care was a holistic way of treating migrant women that enabled disclosure, it could also be the outcome of disclosure as well as one continuous response to providing healthcare. Person-centred care involved being caring and providing emotional support, being (culturally) understanding of DVA, communicating care by showing an interest in women as persons (e.g. asking questions about children), asking sensitively about DVA and listening attentively and non-judgementally, providing information, advice and referrals and ensuring safety, while also respecting women's autonomy (see Figure 3.3). Migrant women reported wishing for and positively experiencing person-centred care – this was framed as culturally competent care in some instances.

Using a 'line-of-argument' approach, I synthesised the overarching constructs to articulate and conceptualise their interrelationships (see Figure 3.4). Figure 3.4 is also divided in a temporal order: pre-consultation (access barriers to healthcare); consultation (constrained help-seeking and help-receiving, or person-centred care received and needed); and needs in post-consultation. Disclosure of DVA was the focal point and, as shown Figure 3.4, it lies conceptually between constrained help-seeking and help-receiving and person-centred care received and needed; this means that disclosure was not inevitably helpful but could lead to both. The needs were mostly related to mental healthcare and continuity of care,

but also referred to wider needs related to immigration status, housing and social isolation – all of which also impact migrant women's and their children's health.

Figure 3.4 partly builds on Ahmad and colleagues' (216) conceptual model, whose study was included in this synthesis. Ahmad and colleagues (216) investigated the help-seeking behaviour of Asian women in the US. This study looked at factors related to help: (1) reasons for delay, (2) turning points and (3) talking to professionals – while also considering the individual, socio-cultural context and immigration status. However, as it focussed on help-seeking, the study did not incorporate the healthcare experiences and the negative role of healthcare – even though this was observed in their study. (216) These negative healthcare interactions were explicitly reported by numerous studies. (202, 208, 209, 213, 214, 216, 218, 221, 227)

Figure 3.4: Overall help-seeking and help-receiving experiences in healthcare



3.4 Quality assessment of the publications using CASP

In the following section, I will describe and discuss the CASP assessment and sensitivity analysis.

I and another reviewer rated all 27 publications, using the CASP ten questions checklist to assign a score, out of ten, for each publication (see Appendix 6). As said earlier, the decision to use a simple scoring system was based on the findings of a previous study, which had evaluated different CASP weighting systems. (231) Publications were categorised as 'good' if they answered 'yes' to 75% or more of the questions, 'moderate' if they agreed with 50-75% of the questions, and 'low' if 'yes' was answered to less than 50 % of the questions. Any discrepancies were discussed and, if required, these were resolved by consulting my supervisors.

Only two publications (211, 219) obtained a score of six, one publication obtained a score of seven (208) and three publications obtained a score of eight (207, 220, 227), see Appendix 6, thus indicating that the identified publications were of good or moderate methodological quality as per the CASP measurement. Six of the 27 publications received a 'yes' to all the ten CASP questions (209, 217, 218, 222-224), followed by 15 publications, which achieved a score of nine (202-206, 210, 212-216, 221, 225-228); all but three studies did not address the issue of reflexivity[41] (202-204, 210, 212, 213, 215, 216, 221), while two of the latter did not report the analysis in detail (206, 214) and one did not mention an ethics committee in the context of interviews with women. (205) Lack of reporting of the analysis was found in four publications (207, 208, 211, 220), which also lacked reflexivity (207, 208, 211, 220) and this was also found in another publications. (219) Additionally, for one publication, the presentation of aims and findings was not discernible (211) and the ethical issues could not be assessed in another (208). Finally, for two studies, it could not be determined whether the chosen research design was appropriate. (211, 219) It should be noted that good quality or high scoring publications were often theses, which did not have the same word restrictions as journal publications; thus, the issue of reflexivity could be addressed. However, perhaps surprisingly, some doctoral psychology theses did not address this. (206, 210-213)

In a sensitivity analysis, I explored whether removing studies that had a lower CASP score (i.e. less than 9) (208, 211, 219) influenced the subconstructs. Overall, 23 of the 28 constructs were affected by removal of the three 'lower quality' papers. However, no sub-

[41] Reflexivity was assessed by the question '*has the relationship between researcher and participants been adequately considered*?' and included, for instance, critical examination of one's own role and potential bias during the formulation of the research questions and data collection.

constructs were dependent exclusively on data from these 'lower quality' papers. Only elements of the sub-constructs were dependent on Perez's findings (i.e. male interpreters impeding communication; and the need for gender congruence may be resolved using Perez's recommendation to simply ascertain women's preference for gender congruence or use of female interpreters). No overarching construct was solely dependent on these lower CASP scoring publications. If the lower CASP quality publications were to be removed, the sub-constructs would be supported by fewer (although sufficient) publications. Thus, I concluded that the removal of lower CASP-scoring studies would not substantially alter the constructs and overarching constructs derived in my synthesis.

3.5 Strengths and limitations

I will now discuss the strengths and limitations of the included studies, as well as my synthesis, and will then close with recommendations for future research.

This systematic search identified 27 publications based on 24 studies, which examined the healthcare experiences of migrant women with histories of DVA. (202-228) Healthcare interactions were only reported by three publications in-depth (202, 207, 209, 214); while eleven examined these very briefly (207, 208, 212-214, 216-218, 221-223), and the remaining publications only mentioned these in the context of negative experiences, barriers (e.g. discrimination) and respective needs. (202, 204-206, 210, 211, 215, 217, 220, 224)

As the healthcare interactions were only investigated in-depth by few publications and otherwise reported briefly, both positively and negatively, or explored hypothetically, my synthesis findings and figures reflects this. The limited data need to be taken into account when interpreting my findings. Therefore, my findings may not adequately capture the healthcare experiences and needs of migrant women as they only reflect current evidence. Further studies are needed to expand my synthesis findings (e.g. to identify novel concepts and add depth to already identified concepts). As the studies were conducted in the US, UK, Canada and Norway (high OECD countries, although with different healthcare and legal frameworks) on mostly Asian and Latina women, the findings may not be transferable to other migrant women and countries. Further studies are needed which include diverse migrant women in terms of their nationalities and countries of residencies and by also including migrant women not accessing help (e.g. via DVA organisations).

The studies were published at various time points – the earliest almost 20 years ago – (e.g. (202, 204)) with the most recent study published in 2017. (228) Thus, due to policy changes, the healthcare responses to DV (and therefore women's experiences) may since

have changed. For instance, in Peckover's study (205), midwives and HVs in the UK did not enquire about DVA, while more recent studies on HVs reported this (e.g. (214)) in the UK, although not in Norway. (228) However, despite this, many barriers and needs of migrant women remained the same.

14 publications were grey literature: theses were either research-based PhDs (n=7, (205, 209, 222-225)) or were part of a psychology doctorate. (n=5 (206, 210-213)) I also included one report (213) and one unpublished paper (214, 218)). Three of the theses (n=3 (205, 209, 222)) were later published in peer-reviewed journals. While grey literature could be criticised for lack of peer review, it can be argued that all theses were formally examined, and the authors were awarded their respective doctorates.

Studies on migrant women in this synthesis were largely dominated by Hispanic/Latin and Asian women. While Latin America and Asia cover a wide spectrum of countries, most studies focussed on Mexican and Indian/Pakistani women, while other ethnicities were absent. This may be explained by four reasons: first, Hispanic and/or Asian women represent the largest migrant groups in the US and in the UK, where most of the studies were conducted. Second, there may be a narrow application of the politically charged term 'migrant', that may exclude certain nationalities (e.g. European/Western nationalities)[42]. Third, in some studies, findings for a subsample of migrant women were not reported separately and were, therefore, not discernible. This was, perhaps, due to the journals' word count restrictions (e.g. (221)) or to protect the participants' anonymity (e.g. (222, 224)). It should be noted that for this synthesis migrant women needed to be clearly discernible. (44, 52, 53, 89, 187) Fourth, the recruitment was largely carried out through DV organisations that may not have been accessed by migrant women who did not seek any help or more affluent migrant women, who may have used different means to escape DVA.

Most of the included women were recruited via DV agencies and not healthcare. Although most women sought healthcare, they found help for DVA using different services (e.g. via the police). The lack of studies examining the healthcare experiences of migrant women may reflect the poor accessing of healthcare. As most women included were recruited via DVA agencies, the findings reported here may not be transferable to other migrant women who had not sought help. Finally, although research on DV in same-sex relationships is important, this synthesis did not examine this. My systematic search identified few studies examining the healthcare experiences of migrant women in heterosexual abusive

[42] For instance, Britons abroad are usually described as 'expats' not 'migrants'.

relationships; even fewer studies examined this for migrant women in abusive same-sex relationships and this, therefore, requires further research.

The included publications were based on heterogenous theoretical or methodological perspectives/designs. There are different stances as to whether these can or should be combined in a synthesis. Relativists argue against this, stating that the studies' respective different epistemological foundations are not feasible or appropriate as each study '*represents a unique view, influenced by differences in theory or method that shape the study*'. (167) I used a broad spectrum of studies with diverse underpinnings, which identified experiences, pathways and needs. None of the studies adopted an extreme relativist or constructivist stance, some did not even explicitly state what theoretical stance they took and were more pragmatic and practical in their approach, therefore, seemed compatible. Previous syntheses adapting meta-ethnographies have demonstrated that it is feasible to synthesise different types of studies. (157-159, 232, 233) Limiting myself to one theoretical or methodological perspective would have narrowed the scope of my synthesis even further.[43]

A synthesis is built on second-order constructs. However, the degree of abstraction of the second-order constructs varied greatly across the papers, with some authors giving a more descriptive account and staying closer to the women's own words. This may be explained, in part, by the respective study's methodological or theoretical perspective being more descriptive and phenomenological and/or the researcher's experience and confidence with the qualitative research methods, as my synthesis included doctoral theses. Some authors did not identify elements present in the women's quotes. For instance, women's requirements of autonomy or characteristics of HCPs were not picked up by the authors' second-order constructs. For instance, Ahmad and colleagues (216) interpreted HCPs' characteristics desired and experienced by migrant women as *'high trust, non-judgemental attitude (friendly listener) and cross-cultural understanding'* and provided the following quote:

> *He [family doctor] spoke to me a lot about my children, about my husband, about the culture, and told me about differences in cultures and not to worry. He gave me attention and a lot of time.*
>
> *((216) p. 618), Asian woman, Canada*

[43] The critical realist stance according to Danermark and colleagues (234) promotes a 'critical methodological pluralism' by considering the ontological and epistemological dimensions of these methodological tools. While meta-ethnography has been placed as objective idealist by Thomas and Harden (175), I used this meta-ethnographical approach in a way that I believe is compatible with the critical realist perspective.

In the above quote, the 'time' and 'showing interest' elements were not identified by the authors. However, these elements were identified by other authors (e.g. (202, 209)). Ahmad and colleagues (216) may not have reported these elements because a) they were not their primary research focus, b) of word constraints or c) the authors' respective backgrounds. This is a benefit of a synthesis approach, which sensitises the synthesiser to important recurring and unique constructs across a range of published studies. These constructs may or may not have been identified by the original authors and this enables the identification of both similarities and divergences across these studies. In cases where a first-order construct was not reflected in authors' second-order constructs, I decided to take these into account as other authors' second-order constructs supported these or used these alongside other second-order constructs as a basis for developing my third-order constructs. This made me question whether migrant women's voices (and, more generally, participants' voices) could get lost in meta-ethnographic approaches in the absence of adequate second-order constructs developed by the corresponding authors.

This synthesis extends knowledge not only in respect to help-seeking, but also gives insight into the overall healthcare experiences (help-receiving), conditions and triggers for disclosure and pathways to support and needs of diverse migrant women. While some authors (209) mentioned other previous studies (e.g. (202, 207)) included in this synthesis, this was not done conceptually, but only to support their own findings (e.g. in terms of, for instance, barriers and/or needs, such as culturally congruent care). None of these studies had drawn together a conceptual model of migrant women's healthcare experiences. Thus, to the best of my knowledge, this is the first synthesis to move beyond the findings of individual studies regarding the healthcare experiences, pathways and needs by drawing inferences across studies. The derived conceptual model requires further research; the models may not reflect all migrant women's experiences, as healthcare access and communication are determined by many factors, such as immigration status and language fluency. It shows that the role of HCPs and healthcare provision needs to be considered too.

3.6 Suggestions for future research

Given the findings, the focus of DVA and perpetrators should be broader in DVA research. If prevention and intervention efforts focus on 'intimate partner violence' by an almost exclusively single male perpetrator, then the DV experiences and perpetrators encountered by migrant women (e.g. by female family members) remain unaddressed in healthcare and beyond.

This synthesis found that person-centred care was found helpful or desired across migrant women. The need for culturally and linguistically congruent care was not desired by all migrant women as there were fears of breach of confidentiality and judgement. This requires further research; it may be related to the healthcare setting (i.e. primary vs mental healthcare) and how migrant women feel about using interpreters in these settings.

3.7 Chapter summary

In summary, this was the first systematic review and qualitative synthesis on diverse migrant women's affected by DVA healthcare experiences. Few studies specifically investigated migrant women's healthcare experiences. This synthesis conceptualises the healthcare experiences and needs of migrant women with histories of DVA pre-, during and post-consultation. I derived three overarching constructs: 1) constrained help-seeking and help-receiving, 2) conditions and triggers for disclosure and pathways to support and 3) person-centred care experienced or needed and brought these together in my line-of-argument. My findings identify an important gap that should be addressed to improve the healthcare response of migrant women affected by DVA.

Chapter 4: **Interview methods**

4.1 Introduction

In this chapter, I will discuss the methods used for my interview study[44]. I will start by succinctly describing the theoretical and philosophical underpinnings of my chosen methods. I will then outline my data collection method, including ethical issues, the sampling technique, recruitment and the interview process. Finally, I will describe the data preparation process and data analysis.

4.1.1 Theoretical and philosophical underpinnings of my methods

My study examines migrant women with histories of DVA healthcare experiences and needs. I therefore investigated experiences, individual actions, social realities and understanding. (235, 236) This reflects a qualitative paradigm which proposes that:

> *useful knowledge can be generated by looking at meaning, with small samples, and that the researcher should not theorise themselves as absent or removed from this process. It also locates knowledge as contextual, and always partial, and as linked to theoretical and methodological commitments.*
>
> *((237) p. 33)*

Qualitative research is a rich, varied and multifaceted field (238), which studies the '*messiness of real life*' ((237) p. 20) and yields in-depth and detailed data. Different methodologies can be used to provide frameworks for conducting research and producing knowledge. My critical realist ontological stance assumes that there is '*a real and knowable world which sits 'behind' the subjective and socially-located knowledge a research can access*'. ((237) p. 27; (238)) Applied to my research, this means that migrant women's and professionals' accounts are *real* and can produce knowledge to improve the healthcare response. This reality is mediated by the women's and professionals', as well as my own, socio-cultural meanings, language and interpretative resources. Consequently, this stance sheds light on the context in which knowledge is produced.

My research was also informed by feminist and other methodologies (239, 240), which try to address power imbalance. (241) Thus, I perceived interviewees as experts, valued their knowledge and sought to make their voices heard and to tell their stories using their own

[44] My PhD was a continuation of the EMiNA (Evaluation of Migrant Women's Needs regarding Domestic Violence and Abuse) study[44], where I had been a part-time research associate from October 2012-April 2013. The EMiNA study was conceptualised and designed by me and supported by my supervisors. It was funded by the Research Capability Funding from the Avon Primary Care Research Collaborative. Here I had carried out semi-structured interviews just before the start of my PhD; these interviews had not been analysed. EMiNA was the starting point for my PhD and the interviews were used for my PhD, which started on the 1st of May 2013.

words. At the same time, I also tried to adhere to the critical realist principle that some accounts of 'reality' may be a better representation than others and that it is feasible (even desirable) to adjudicate between these different representations. (241) This requires considering whether my 'expert' knowledge as a researcher and skills to look across cases should be valued over and above the other actors'. (242) This is compatible with the critical realist perspective which includes the researcher's perception as one possibility to view the *real* world. Yet, I was cautious and used reflexivity to counterbalance this. Qualitative research recognises '*the subjectivity of the data we analyse as a strength rather than a weakness*'. ((237) p. 6)

4.2 Method of data collection: semi-structured interviews

Qualitative research utilises methods that gather and analyse qualitative data – that is non-numerical data – such as transcribed text derived from interviews (243), ethnographic observations (244), focus groups (245) and diaries. (246) Interviews are a key qualitative method of gaining insight into people's experiences and perspectives. (247) As my overall aim was to investigate the healthcare experiences and needs of migrant women affected by DVA, from the perspective of abused migrant women and professionals, employing a qualitative study design and using interviews seemed fitting.

Interviews can be described as 'purposeful conversation' yet they differ from normal conversations regarding their objectives and the roles of the researcher and participant. (248) Interviews can have diverse forms; their spectrum ranges from using a highly structured format, where questions and answers are pre-set and asked in a particular order (e.g. in a standardised interview schedule) to '*informal, unstructured, naturalistic, in-depth discussions*'. ((249)) Interviews offer an ideal opportunity to follow up and probe answers, as well as to investigate motives and feelings. There are pros and cons to using a specific type of interviews: more guided or focused interviews are easier to analyse and require less time (249) but are more constrained because of pre-set questions and may, therefore, miss information that may be crucial for interviewees. Unstructured interviews, on the other hand, may be more challenging and time-intensive to analyse but may yield more meaningful data from the participants' perspective.

I used semi-structured interviews with topic guides as, methodologically, they were the best fit for this work. This is in line with the critical realist perspective that theoretical ideas play an important role in guiding the research (250), which notably includes the questions asked. (241) Semi-structured interviews provide some structure and ensure that the same broad issues are covered in each interview, but also allow flexibility for participants to raise issues of importance to them. (241)

4.3 Ethical issues

The following section briefly discusses some ethical issues involved in conducting research with research participants, in particular with my target population. These issues will be addressed throughout this chapter, as well as in the discussion chapter.

When conducting research on research participants, among others, the World Medical Association (WMA) Declaration of Helsinki (DoH) (251) provides '*Ethical Principles for Medical Research Involving Human Subjects*'. A crucial question to be considered is whether the research might be causing any harm to participants, such as psychological distress. This was particularly relevant due to the sensitive nature of my study, which may be especially distressing to migrant women. Another important aspect was obtaining informed consent prior to conducting research, which I will explain later.

Ethical approval represents an independent review of the scientific value and implications of a study regarding the dignity, rights, safety, and wellbeing of research participants and should always be sought before carrying out any research involving human participants. For my research, I obtained ethics approval from the Health Sciences Faculty Research Ethics Committee[45] at the University of Bristol (see Appendix 7), as well as National Health Services (NHS) Research and Development (R&D) approval to interview migrant women exposed to DVA and professionals from third sector agencies and the NHS.

4.3.1 Ethical conduct of research to avoid harm

As noted above, research on DVA poses a risk to participants, by bringing up traumatic memories, and to the researcher as the interview may elicit distress and vicarious trauma[46]. Carrying out the interviews in the women's homes may be dangerous for both the interviewees and the researcher due to, for instance, the risk of the perpetrator being there. To minimise these risks, I used recruitment (see Appendix 8) and researcher safety protocols (see Appendix 9) adapted from previous DVA research at the University of Bristol. These outlined: a) how to recruit suitable participants by ensuring that they were safe to take part in my research and b) how I should behave in a situation where I needed to break confidentiality due to, for instance, safeguarding issues. Thus, there were various strategies in place for me to debrief and have regular supervision to address possible risks.

4.4 Sampling strategies

In this section, I will describe my sampling strategies.

[45] This was formerly known as the Faculty of Medicine and Dentistry Research Ethics Committee.
[46] Vicarious trauma is also referred to as secondary trauma and describes indirect exposure to a traumatic event through first-hand account or narrative of that event, which can result in enduring psychological consequences such as nightmares and anxiety.

Sampling refers to the techniques used to select participants or groups from a wider population. Particularly in quantitative research, the aim is to select a sample which is representative of the population as a whole, with the underlying assumption that inferences or conclusions can be drawn for the population from which the sample was taken; this makes sampling a crucial part in the design of the research. (252) The generalisability or (external) validity of qualitative studies may be questioned if they do not include enough participants' views. However, qualitative research, according to Silverman (253), does not necessarily aim for representativeness when selecting participants. Instead, the participants' unique experiences and depth of data should take precedence. (253) In some qualitative research traditions, alternative forms of terminology have been developed, such as using transferability in place of generalisability, trustworthiness in place of reliability and credibility in place of validity. (184) Theoretical or conceptual generalisability, or transferability, is usually the goal in qualitative research. (237) This is particularly the case for qualitative research that may be described as 'post-positivist' and fits with a paradigm – such as critical realism, within which qualitative equivalents to quantitative terms are acceptable. However, in other forms of qualitative research, terms such as transferability would not be used as researchers would want alternative criteria by which to judge the quality of qualitative research.

Purposeful sampling describes a type of sampling, whereby the researcher decides which individuals or groups[47] to include, based on them being able to provide 'rich information'. (254) This includes relevant experience (i.e. being a migrant woman affected by DVA or a professional dealing with affected women), specialist knowledge of the research topic, for example 'key informants' and 'experts', being capable and willing to participate in the research process, and having the potential to provide valuable and in-depth data. (255) Maximum variation is one purposeful sampling approach to achieve heterogeneity among participants (e.g. regarding nationality, profession, DVA training, gender), with the aim of generating key themes that apply to a diverse sample.

Within a purposeful strategy to identify people with relevant experience and from relevant backgrounds, I originally aimed to be able to purposefully sample women and professionals according to criteria such as being from diverse countries, age groups, professionals serving areas with a high and low number of migrant populations. In practice, however, sampling was mostly snowball and opportunistic. In snowball sampling (254), the process of sampling started by asking, for instance, DVA organisations or relevant professionals to identify and nominate another potential participant. (256) Snowball sampling is useful

[47] However, this can also include settings, times or types of experience or phenomenon.

when the research topic is sensitive, and people do not easily self-identify or are inaccessible. (252) This was particularly relevant for my research as ethical (safety) concerns were key when identifying migrant women. Here DVA professionals were used as gatekeepers to access women. Snowball sampling often occurred without any prompts from me: when speaking with or interviewing professionals, they often voluntarily suggested other professionals or migrant women and put me in touch with them (see next section). The strength of recruiting women through services was that it allowed me to interview this 'hard-to-reach' group, while ensuring that the women were looked after in refuges or by key workers if issues arouse after conducting the interviews.

4.5 Recruitment strategies

I used various recruitment strategies. As noted above, to ensure interviewees' and my own safety, all migrant women were recruited only through DVA agencies or other professionals. I did not recruit any migrant women who had not been in touch with DVA agencies as I wanted to ensure that, if needed, these women had support after my interview. For this, using existing contacts and collaborations within the Centre for Academic Primary Care (CAPC), University of Bristol, and DVA research programmes, I contacted relevant DVA organisations and healthcare professionals. These agencies and professionals acted as gatekeepers and controlled my research access. ((257), p. 126)

4.5.1 Recruiting affected migrant women

Migrant women were recruited through DVA organisations, using two strategies:

First, I sent an email to DVA organisations providing information about the study, which consisted of the covering letter, participant information sheet (PIS) and consent form (see Appendix 10,11 and 12, respectively). Staff from these agencies asked suitable women about taking part and then secured consent from these women to be contacted by me (appendix 13). I then contacted prospective participants by telephone to provide more information about the study, answer questions and then, if women agreed, arranged the interview. Second, I attended a meeting in one DVA refuge to describe my study. I distributed the PIS and consent forms (see Appendices 11 and 12) and asked if any women were willing to take part. I then collected a '*willingness to be contacted*' form from three interested women (Appendix 13). I then telephoned these women to discuss the interview further. As these women were still willing to take part, an interview time was arranged[48]. Unfortunately, it is not known how many women were asked by staff to enable me to comment on the response

[48] All interviews were conducted more than 48 hours after the initial distribution of the study information and consent forms.

rate. In the interviews, professionals reflected that they could put me in touch with some women, who I then interviewed. Hence, professionals had an important gatekeeper role.

Two women were suggested as professionals; however, in the interviews, they disclosed their own DVA experiences. These two and other migrant women provided unique multiple perspectives as migrant women who had experienced DVA themselves, professionals, community members and friends who dealt with other migrant women affected by DVA. For the purpose of my analysis, these women were treated as migrant women.

4.5.2 Recruiting professionals

In this section, I will describe the process of recruiting professionals.

4.5.2.1 Recruiting staff from DV agencies and other sectors

I contacted DVA organisations by email to ask whether any staff would be interested to take part in my interviews. This email contained a covering letter, an information sheet for professionals and a consent form (see Appendices 14, 15, 16) and was forwarded to staff. I was put in touch with interested staff who I then contacted by email, text or telephone call to explain the study, answer questions, and if interested, arrange an interview. Unfortunately, I cannot assess the 'response rate' to this enquiry.

4.5.2.2 Recruiting GPs

To recruit primary care professionals, I emailed various practice managers of general practices and attached a covering letter, information sheet for professionals and consent form (see Appendices 17,18,15). Some of these practices had been suggested by one DVA organisation and had undertaken the Identification to Improve Safety (IRIS training)(153, 258, 259)[49] to help women affected by DVA. Unfortunately, this strategy was not successful. The few practices that were interested declined to take part as the EMiNA study (for which I was conducting the interviews) was not registered with the Primary Care Research Network (PCRN), which supports and credits primary care professionals undertaking health research. I only interviewed one GP; here the contact was established via another professional.

[49] http://www.irisdomesticviolence.org.uk/iris/

4.5.2.3 Recruiting other professionals working in healthcare

I spoke to a variety of professionals who suggested key people working with migrant populations in the healthcare setting or who had other relevant knowledge. I then contacted these professionals via email, explaining my research, enclosing the covering letter, an information sheet and consent form (see Appendices 16,17, 15). I initially arranged informal conversations with three healthcare professionals, which was followed by formal interviews with them.

4.5.3 Inclusion and exclusion criteria for participants

I will now describe my inclusion and exclusion criteria for both migrant women and professionals.

4.5.3.1 Migrant women

The inclusion criteria for the migrant women were: (1) having experienced DVA using the same definition as in the introduction and being (2) foreign-born and having migrated to the UK; (3) aged 18 years and over, (4) currently living in the UK, (5) willing to participate in the study, and (6) able to communicate in English. If women were eligible but did not speak English sufficiently well to take part, bilingual support workers, or interpreters (who had been trained in providing help for DV victims) within the third sector agencies, were asked to join the interview. For this work, the interpreters were offered an appropriate fee.

Migrant women were excluded if they (1) had not experienced DVA, (2) were under 18 years old (3) were too distressed to take part or (4) did not consent to being interviewed.

4.5.3.2 Professionals

The inclusion criterion for the professionals was that they had worked with migrant women with DVA experiences and were currently in the UK, willing to participate and able to communicate in English. Apart from declining to consent, no additional exclusion criteria existed for professionals.

4.6 Description of the interview process

This section describes the interview process, including seeking informed consent, interviewing participants and reimbursement. All the interviews were carried out between the end of February and mid-April 2013.

4.6.1 Developing the topic guides

The topic guides for all three groups of interviewees (i.e. migrant women, HCPs and DVA or wider allied professionals, such as interpreters) were informed by the DVA literature on

migrant women (e.g. (202)) (see Appendix 20,21,22)[50]. This gave insight into, for instance, various barriers to accessing healthcare, which were noted down as topics (with prompts) to cover during interviews. The structure of the topic guides was informed by suggestions by Arthur and colleagues. (260) Rather than including preset questions, topics were broadly outlined with open questions and prompts following what was anticipated to be a natural 'flow' to the interview. Flexibility allowed topics to be covered in various orders, in response to the interviewee's answers and language. The interview guides for all interviewees were quite similar, covering migrant women's experiences (first-hand) and professionals' experiences (first and/or second-hand) of DVA and healthcare (see Appendix 20,21,22).

4.6.2 Piloting the topic guides

The topic guides were piloted with three female colleagues. All had migrated to the UK from different countries and one had, previously unknown to me, experienced DVA. This made me aware that professionals may have their own DVA experiences that they may be willing to share. For this reason, I always carried two topic guides to be able to draw on both, if professionals decided to disclose their own DVA experiences.

My colleagues gave me valuable feedback regarding the wording, order and duration of the interview. For instance, some questions were simplified and, to accommodate time constraints, I added '*briefly*' into the question (e.g. '*I want to briefly ask you about your role in this setting*'). The pilot interviews also gave me insight into what topics should be prioritised when faced with time constraints. I did not include any of the pilot interview data in my data analysis.

4.6.3 Seeking informed consent

The PIS mentioned that the research had the potential to cause distress and this was also reiterated verbally when discussing the study prior to the interviews. The limits of confidentiality were also addressed by explaining that if the interviewees disclosed any serious risk of harm to themselves or others I would need to disclose this to my supervisors (see Appendix 19). I explained to participants that the interview could be stopped at any time and that they could also withdraw from the study at any time without needing to give me any reason, in which case their interviews would not be used. I further explained that, in this case, participants would still receive the promised fees/vouchers and (if applicable) travel expenses. I reiterated this after the interview.

[50] The interviews were conducted before my qualitative synthesis. This timeline will be reflected in my discussion.

The consent forms were explained before the start of the interview. I sought informed consent (see Appendices 12, 16) before conducting the interviews and consent was an ongoing process during and after the interview, where I checked with the women and professionals whether they were still happy for me to carry on with or use the interview. This informed consent was based on verbal information about the study and on the written PIS (see Appendices 12,16), which explained the study in plain English. All written information was only available in English, as resources to provide other languages were lacking and no specific group of migrant women was targeted for this study. When interviewing a woman with the help of an interpreter, this information was handed out again and the interpreter translated and explained it to the woman. Participants were aware that the study was voluntary, and they did not have to answer a question if they did not want to.

4.6.4 Interviewing participants

There are often power differentials in interviews (241) which Bourdieu termed 'symbolic violence'. (240) Throughout the research interview process, I was aware of the power imbalance. I tried to minimise this using various strategies, such as by not being too formally dressed and letting participants choose where the interview should take place, when using an office I made sure the chairs were of the same height, that they were facing each other and that participants could choose where they wanted to sit. (237) Before the interview, I made sure to engage in ice-breaking conversation first. I also emphasised that I was interested in the participants' knowledge, experience and recommendations as a means of improving the situation of migrant women with histories of DVA. By doing this I hoped to convey the message that we were co-experts (241) by asking participants to make recommendations and neutralise power imbalances. I also asked participants to choose pseudonyms (fake names) and thanked them for their willingness to take part in the research. By adhering to the above I hoped to equalise the relationship and avoid objectification of my interviewee partners (for more reflection, see discussion).

Before the start of the interview, I introduced myself as a researcher from Germany. With participants who picked up my Arabic name (both migrant women and professionals), I explained that my father was from Jordan, but that I did not speak Arabic. I encouraged my participants to ask any questions about the study.

To ensure a gentle introduction to the interviews, the topic guide for women and professionals (see Appendices 20,21) was designed to start and finish with easier questions. For instance, migrant women were asked first about general demographic information and

their migration history and the interview ended with questions about what women or professionals would recommend for improving the healthcare response.

While interviewing, I was attentive to any signs of distress. A few migrant women became upset and cried when retelling their experiences. I responded empathically, acknowledged their distress and asked them whether they wanted a short break, to change to another question or stop the interview altogether. Despite becoming upset, these women wanted to continue with the interview. I partly debriefed and talked about my interviews in the supervision given by Sue Penna, a clinical supervisor.

After the interview, a debriefing in the form of an informal conversation took place to find out how the participants had felt during the interview, whether the participants had any questions or comments and to let them know about support agencies. All participants were offered an information sheet with local and national sources of help for DV. I reiterated that participants could withdraw at any time and that they could also telephone or email me if they later changed their minds.

After the interview, I also recorded all my impressions about the interviews (e.g. setting, duration of the interview, reflections and tentative themes) in my field notes and my reflective diary/journal. In my discussion, I will deal with my reflections in more detail.

4.6.5 Reimbursement

In appreciation of their time and contribution to the study, migrant women [51] and professionals were reimbursed financially; this was explained in the participant information sheets. Migrant women received a high street voucher of £10 pounds (that could be spent in a range of shops), while professionals were reimbursed with up to £60 pounds. This maximum amount for professionals was based on standard hourly rates recommended by local primary care organisations and covered professionals' time for taking part in the research (for example, if a GP gave up clinical time and needed to arrange cover). The practice or organisation (e.g. one DVA organisation) was reimbursed when professionals took part during their working time. Some professionals were reimbursed directly if they were interviewed outside of working hours, while others did not accept any reimbursement. The differential in financial reimbursement between women and professionals could be viewed as ethically problematic as it may be interpreted as valuing the participants' input differently. However, this is standard practice within health research, partly due to concerns that higher reimbursement amounts for patients or

[51] Migrant women were also eligible to receive a reimbursement for travelling to the interview location. However, this was only the case for one woman, as all the other women were either interviewed at their home, the refuge or at work.

members of the public might act as an inducement to participate and was approved by the research ethics committee.[52] I will reflect on this issue in more detail in my discussion chapter.

4.7 Data preparation

In this section, I will describe how I prepared my data for analysis, which included checking and anonymising my transcripts.

4.7.1 Lost in transcription

As explained earlier, 19 interviews were audio-recorded. For transcribing the interviews *verbatim*, I used an approved agency. Transcripts are textual versions of audio or audio-visual data and only reflect a representation of the audio-recording. (237) Transcripts can vary in how they are done and what they capture; that is, not only spoken words are noted but also non-linguistic features (e.g. laughter, verbal utterances such as 'erm'). For my transcription instructions, see Appendix 25. To ensure that the details of the interviews were kept confidential, a confidentiality agreement was used (see Appendix 26).[53]

Some of the returned transcripts were poorly transcribed due to the strong accents of some of my participants, both women and professionals. These transcripts were returned with a high number of unclears – that is, unrecognisable sections of the interviews. The number of unclears within a single transcript ranged from none (n[54]=1), to under five (n=11), over ten (n=4), up to 30 (n=2) and 89 (n=1). When checking the transcripts against the audio-recordings, in some interviews the content of the participant's responses had been altered – thereby changing its meaning entirely, and in one case the grammar had been corrected, giving the impression that the interviewee had a much better grasp of the English language. Even after the transcribing agency had been contacted to address these issues, sometimes several times, the quality of some of these corrected transcripts remained poor. Thus, much time was taken up going through the transcripts and listening carefully to the audio recordings, filling in unclears and correcting both content and grammar. The upside of this was that it enabled me to re-engage and familiarise myself thoroughly with my data. (261) The issues surrounding transcription will be more reflected upon in my discussion.

All corrected transcripts and demographic information sheets were imported into NVivo10 (262) for data management and coding.

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[53] I also let the transcribing agency know that my interviews could be distressing as they dealt with DVA.
[54] The n here refers to the number of transcripts in which the unclears were found.

4.7.2 Anonymising data

I asked my participants to choose a pseudonym for themselves to aid their anonymity. The majority, particularly migrant women who had experienced DVA, chose this with ease; however, some professionals wanted to share their real names. This was problematic as I wanted to disguise everyone's identities for safety reasons and had outlined this in my ethics application and consent form, which they had signed. This denoted a conflict of interest and an imbalance of power, which I held as the researcher (for more detail see my discussion chapter). I resolved this by contacting the professionals again who then agreed for me to use a pseudonym.

To ensure safety and anonymisation, participants' identifiable information was also changed (e.g. all professionals in the healthcare sector became HCPs). However, this approach posed a recurring challenge as I sought to preserve the integrity of the data while also protecting participants' anonymity. After discussion with my supervisors, I decided not to include contextual summaries of my participants (i.e. summary of women's migration and DVA trajectories) to ensure their anonymity and instead presented characteristics in a summary box. When two quotes together run the risk of identification, I did not use the pseudonym under the quote. More detailed reflection on these issues will be provided in my discussion chapter.

4.8 Analysis

I used thematic analysis to analyse my interviews as this is a foundational, accessible and flexible method for qualitative data analysis and shares many core elements of qualitative approaches, such as finding patterns and comparisons. (263) Although thematic analysis has been widely used, Braun and Clarke maintained that it remains *'poorly demarcated'*. (264)

> *Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic. ((264) p. 79)*

A theme captures something important about the data in relation to the research question and represents some level of patterned response, or meaning, within the data set. (264) Thematic analysis allows the researcher to put an interpretational framework around the findings; this is useful in that it can summarise '*key characteristics of a large body of data and offer a 'thick description' (33)* of the data generated. Thematic analysis has only recently become a method in its own right. (237)

In thematic analysis, researchers are not required to subscribe to the implicit theoretical commitments, such as those needed for grounded theory (265) – that is, they do not need

to generate a theory grounded in their data. As thematic analysis is not tied to any single theoretical framework, it can be used variedly. Coding can be deductive ('top down') or inductive ('bottom up'). (265) I used both types of coding, and my coding was data-derived, that is, it was closely related to the '*explicit or semantic content of the data*'. (265) Consequently, my analysis was mostly descriptive and semantic, in that it aimed to examine, document and describe the nature of healthcare experiences and needs of migrant women. (264)

Thematic analysis can be divided into six phases (264):

> 1. Familiarising – (i.e., immersion in the data: here I read and re-read my transcribed interviews on paper and noted down initial ideas in the form of memos).
>
> 2. Generating initial codes: here I coded '*interesting features of the data systematically across the whole data set, collating data relevant to each code*' (264) This was followed by sorting, merging, subsuming or differentiating them (see below).
>
> 3. Searching for themes: here I organised codes into potential themes, sub-themes and overarching themes, assembling all data relevant to each potential theme. First, I arranged themes, then arranged them into possible overarching themes and described facets of a theme as a sub-theme.
>
> 4. Reviewing themes: here I checked whether my themes worked in relation to my coded extracts and the entire data set. I concluded that the 'working themes' I had allocated needed reworking to capture the full range of healthcare experiences reported by women.
>
> 5. Defining and naming themes: here I revisited the 'working themes' changing the name, number and organisation of themes.
>
> 6. Producing my report: here I wrote up the themes as interpretive summaries interspersed with illustrative verbatim quotes from the participants. These formed the basis of my findings, which will be presented in the next chapter.

I analysed my data using both deductive and inductive coding. While I anticipated certain codes from previous research, such as '*fear of consequences*' as a barrier to disclosure, I did not approach my data deductively with a list of pre-defined codes that I applied to my data. Instead, I stayed close to the data and I derived emergent (inductive) codes. Many of these codes reflected the existing literature, while some seemed new (e.g. need for healthcare advocacy).

I started my analysis in 2013, during which I generated some preliminary themes and insights. I then re-visited and furthered my coding and analysis in detail in 2017 and this timeline will be discussed in the final chapter.

I began my analysis with line-by-line coding. The codes were then used to generate an initial coding framework. As analysis progressed, I began to focus my coding on sections of

transcripts that I felt were most relevant to my research questions. While many interviews elicited interesting and contextually important data, some of this was not relevant to my specific research questions. For instance, migrant women shared with me their life stories and experiences of DVA in some detail. While I valued these accounts and recognise the privilege of hearing these stories, I wanted to focus on their healthcare experiences and needs for this PhD. Therefore, these parts of the interviews were given broad codes.

I shared my coding framework with my supervisors and selected colleagues, using these discussions to check my framework and incorporate other perspectives in the analysis. This provided a way of ensuring the trustworthiness of my analysis process and the credibility, or plausibility, of my interpretations. (184)

As part of the process of theme development, I drew on the constant comparative method (266), which forms part of the methodology for building grounded theories from qualitative data. The constant comparative method describes the analytical process of continually comparing different data elements for similarities and differences during data collection and analysis (conducted in parallel, iteratively). During this comparative process, data elements are compared with others and grouped according to their conceptual similarity. Constant comparative techniques help to a) distinguish one category/theme from another and b) to identify properties and dimensions specific to that category/theme. ((267) p. 73) Consequently, elements of data with the same code label were compared for similarities and differences within the same code and data elements with different coding labels were compared to check distinctiveness. These processes led me to assign some data elements to more than one code label or recoding and grouping them with other more similar data elements.

Following on from this, I merged codes into preliminary themes (e.g. coercive control, language barriers) and overarching themes (e.g. facilitators, barriers).

The following table shows some of my initial coding, as assigned to a section of an interview transcript.

Table 4.1: Overview of earlier codes

Speaker	Transcript excerpt	Initial codes
RES:	It is, um, okay let me think this, you know erm, it doesn't have to be a language, it's body language, no matter which language we speak or understand, if you really kind towards me your body will tell me, you know do you know what I mean? You don't have to say, be humble you know and talk to... not rushing, (makes a noise) okay just go, but actually spending, I know time is expensive, but you are not going to get any better, you know the patient is not going to get any better by rushing it you know so spend a little time and see what's going on. It might be, come as emergency, tell them to make a proper appointment. And that proper appointment talk to them deeply and find out what is going on you know. But if you just say, 'okay the other patients are waiting so how can I help you?' Well it's this lady is not even speaking proper English, you know. All the things, oh just go away. Then you will shut down. Does that make sense?	Importance of congruent and empathic non-verbal communication Description of non-verbal communication which evokes the impression of kindness (Note: in response to my question of what constitutes kindness) Time constraints: HCPs rushing patients Awareness of time constraints in healthcare Time constraints barrier to communication and getting better; time enables communication Need to explain healthcare system and time constraints Time enables communication, asking Language barriers exacerbated by time constraints Silenced
INT:	Yes. She is not being heard?	
RES:	She is not being heard. So because she'll shut up, because she is erm, not good, not feeling good she keep come back, because this is her hope and then she will be at the GP's door 8'o'clock in the morning and so waste for the GPs time and for this lady's time and nobody is getting better you see.	Silenced No improvement; repeat visit Ineffective interaction Waste of time

Key: RES: Respondent, INT: Interviewer

This extract also illustrates that I tried to ensure that I had understood my participants correctly by paraphrasing their responses. Later in my analysis, I realised that the paraphrase 'seen but not heard' captured the experiences of the interviewed migrant women and most of the professionals' second-hand accounts. This paraphrase was then turned into my first overarching theme, which will be presented in the next chapter.

Although I tried to treat all my participants equally, some women and professionals had experienced and reported more in-depth healthcare interactions and, thus, addressed my

research questions in more detail, while others had reported limited healthcare interactions and gave less rich descriptions. Thus, in the presentation of my findings (in the next chapter), some interviewees are represented more than others.

4.9 Chapter summary

This chapter has outlined the theoretical and philosophical underpinnings of my chosen methods and explained why I chose semi-structured interviews as my method for data collection. I have discussed ethical issues, recruitment and the sampling of my participants, the interview process and data preparation, as well as the data analysis using thematic analysis. Some of these issues will be revisited in the discussion chapter.

In the following chapter I will report my findings.

Chapter 5: **Interview findings**

5.1 Introduction

This chapter presents the findings of my thematic analysis of interviews with migrant women with histories of DVA and professionals working with these women. The overall aim of my interviews was to identify the healthcare experiences and support needs of migrant women with histories of DVA[55]. The objectives of this chapter are to report:

1) the healthcare experiences of migrant women with histories of DVA

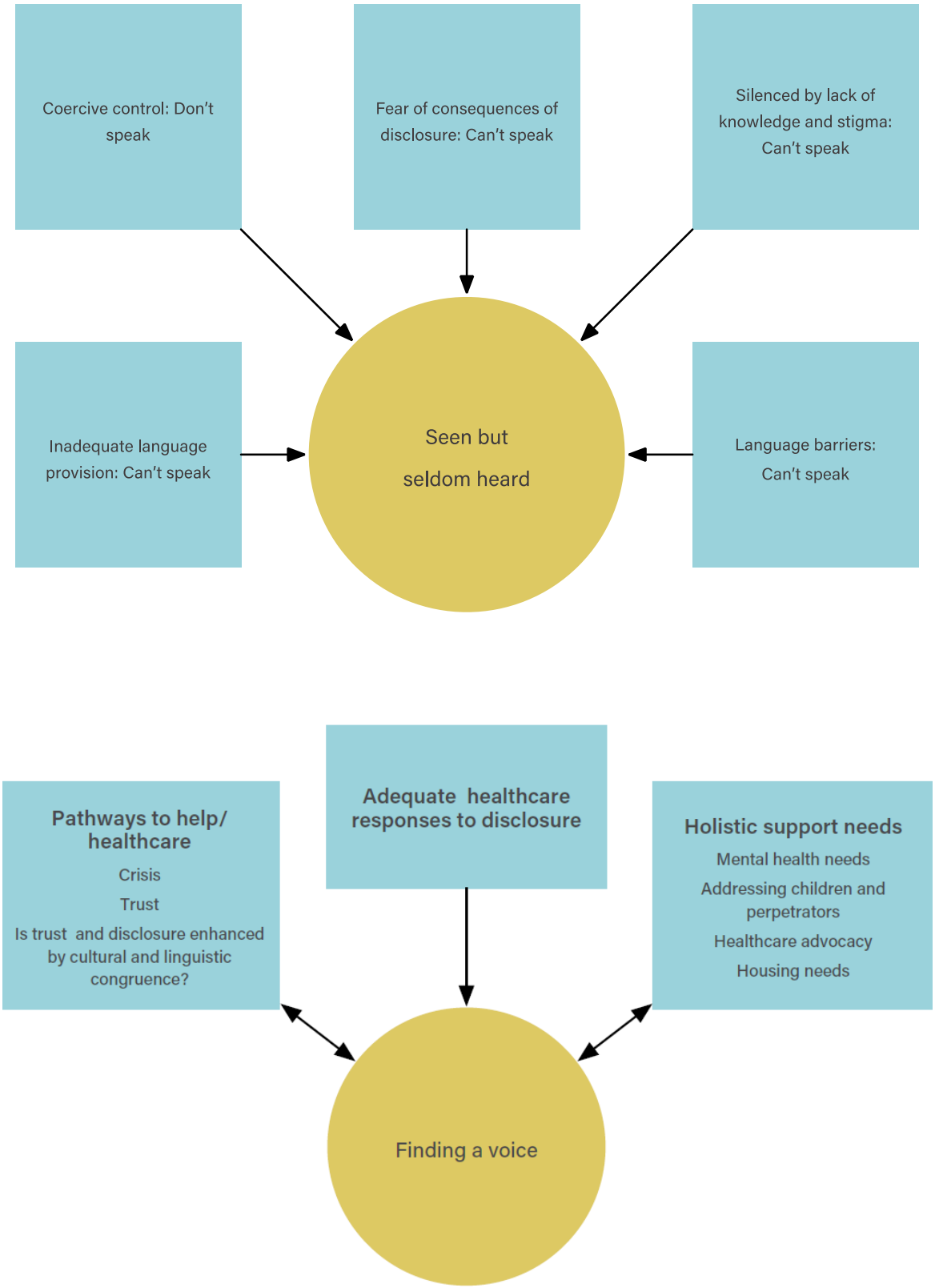
2) how these women sought support following exposure to DVA

3) the unmet needs among these women.

Based on my thematic analysis of the interviews, I derived two overarching themes: *seen but not heard* and *finding a voice*. Both themes incorporated a range of themes and sub-themes (see Figure 5.1 below). *Seen but not heard* contained the following themes: coercive control; fear of consequences of disclosure; lack of knowledge; language barriers; and inadequate healthcare response. *Finding a voice* included the themes: pathways to help/healthcare; adequate healthcare responses; and holistic support needs after separation. *Seen but not heard*, therefore, addresses objectives 1 and 3 (as negative experiences often translate into unsupported healthcare needs). *Finding a voice* addresses all objectives: 1 (adequate healthcare response), 2 (pathways to help) and 3 (holistic needs after separation).

[55] The interviews yielded considerable data, some of which was not directly relevant to my research questions. For example, migrant women's narratives often focussed on the encountered violence, which was not the focus of my PhD thesis. Similarly, within professionals' accounts of dealing with migrant women, some data was not relevant to healthcare and was therefore not presented in this thesis.

Figure 5.1: The overarching themes and themes



Key: Circle: overarching theme. Rectangle: theme.
A hierarchical relationship between overarching themes (circles) and themes (rectangles) is shown in a single solid arrow (adapted from Braun and Clark 2013 (237) p.233). However, there were also relationships between themes, such as between language barriers and lack of knowledge. To simplify this, these arrows are omitted here. There were reciprocal relationships between, for instance, an adequate healthcare response and enabling finding a voice, and vice versa.

This chapter presents the findings for migrant women and professionals together. Some migrant women with DVA experiences were also professionals and provided insight from both perspectives (i.e. their own and professional experiences of migrant women affected by DVA). Professionals shared their first or second-hand experiences of migrant women's healthcare encounters and needs (i.e. their own interactions with migrant women or migrant women's accounts of these). I will present and interpret my findings, illustrated by *verbatim* quotes from participants. The presentation of my findings will include professionals' comparison of migrant and non-migrant women' s experiences. However, as previously mentioned, I will discuss my findings in the context of the wider literature in Chapter 6. Here, I will start by giving a brief description of the participants and the DVA experiences of interviewed migrant women.

5.1.1 Description of participants

Table 5.1 and 5.2 below summarise women's and professionals' characteristics. Migrant women came from four different continents and were diverse in many aspects, such as family or legal status and educational background. All had separated from their abuser(s).

Table 5.1: Socio-demographic and other characteristics of migrant women

Migrant women (n=8)	
Country of origin	Ivory Coast, Libya, Sudan, Somalia, Romania, Ukraine, Brazil, India
Age groups	27-41 years; mean age: 34.5 years
Family status	Separated (n=6); divorced (n=1), re-married (n=1)
Children	Yes (n=6*); no (n=2)
Number and age of children	No of children: 0-6 (mean 2.4); aged 2-20; women who had children aged younger than 10 years (n=5)
Housing/Accommodation	Refuge/safe house (n=5), rented/own accommodation (n=3)
Educational status	Formal educational background ranged from no or primary school (n=2); to secondary school (n=2), A-Levels (n=1); to university degrees (n=3)
Duration of residence in the UK	Residing in the UK from 3-25 years (mean duration: ≈ 8 years, median 5 years)
Legal status in the UK	EU residents/indefinite leave to remain (n=2), British citizens (n=2); seeking independent residency (n=4)
English skills	Ranging from proficient/good (n=5) to very broken English skills (n=2) or no or hardly any English (n=1); some had learned English at school/university (n=5)
Working status	Working (n=2); not working (n=6)
Receiving benefits or help from charities when not eligible to public funds	Yes (n=6), no (n=2)
Religion	Christian (n=3; 1 specified Catholic); Muslim (n=3); Sikh (n=1); none (n=1)
Abuse type	Psychological (n=8); physical (n=7); sexual abuse (n=2; e.g. rape); financial abuse (n=5) and coercive control (n=8) including imprisonment (n=2); pressure to have children (n=1); forced marriage (n=1); witnessing DVA between parents (n=1)
Time of DVA in relationship	Most women had experienced DVA within the previous 2 years by husband and/or family-in-law, but one woman also reported historic DVA
Perpetrators	Husbands or previous husbands (n=8), family-in-law (n=2) particularly mother-in-law (n=2), own family (n=2)

* Four women had children from previous marriages/relationships.

The professionals worked primarily in third sector DVA services[56], followed by the healthcare sector, or both. It should be noted that the professionals working in healthcare were not all medically trained; some were employed for their language and community knowledge or DVA expertise. Three professionals had migrated to the UK, while three others had parents, or at least one parent, who had migrated to the UK.

Table 5.2: Socio-demographic and other characteristics of professionals

Professionals (n=12)	
Occupations	GP (n=1); Healthcare trainee (n=1), social worker (n=1), independent domestic violence advisor in hospital (n=1), various roles in the DVA services (n=6), academic policy and healthcare research (n=1), health improvement officer (n=1)
Gender	Female n=11, Male n= 1
Age groups	30-70
Country of origin	United Kingdom (n=9); Sudan (n=1); Poland (n=2)
Number of years in the UK if foreign-born	8-13 years
Migrant generation	First generation (n=3), descendants of migrants (n=3), N/A (n=6)
Country of origin of parents	Pakistan (n=2), unknown (n=1)

[56] In the following section, I will refer to these organisations as domestic violence and abuse organisations, which are delivered by the third or voluntary sectors or local authorities.

5.1.2 DVA experience, migration trajectory and perpetrators

All migrant women had experienced multiple forms of violence[57] mainly from their husbands, but some also from their in-laws or own parents. All women had experienced emotional and psychological abuse, such as threats from their husbands, and/or from their in-laws. These threats included harming or killing women, taking their children away or deporting them. Seven women reported physical abuse and one woman reported being repeatedly raped. Coercive control was also experienced by all women. One woman specifically reported imprisonment and control of all outside contacts by her husband, including not being allowed to contact her own family, being left in the country of origin and separated from her children for months. Five women also reported financial abuse, including complete control of all finances.

Some women had experienced or witnessed multiple forms of violence by multiple perpetrators, including by their own parents (e.g. witnessing parental DVA, and experiencing emotional abuse and arranged/forced marriage by their parents[58]). As recounted by two women, their respective mothers-in-laws were abusive and responsible for marital conflict or conflict escalation. For instance, one mother-in-law threw her daughter-in-law out of the joint family home and one experienced a physical attack by her parents-in-law. Two other migrant women had experienced wars and political conflict and, as a result, reported traumatic experiences (e.g. killed relatives). Two women reported discrimination in the UK due to, for instance, wearing a hijab (headscarf) and having an accent. Six women had 'arranged' marriages – in four cases this was arranged via family and friends and in two cases, women met their respective husbands online. One woman met her husband through her mother-in-law who was looking for a suitable daughter-in-law. This mother-in-law was later abusive and violent towards her daughter-in-law.

Five women had migrated to England to marry their respective husbands and experienced loneliness and social isolation. For these women, the violence started after migration either immediately or shortly afterwards. This was also the case for one woman, who migrated with her family to England before experiencing a forced marriage, and another woman who

[57] As I was interested in the healthcare experiences of migrant women, I did not seek to probe in detail women's DVA experiences, although all women shared them. Respecting their wish to share their experiences, I let women describe how much they were comfortable with. However, the DVA experiences I report in this chapter may well be incomplete as they were not the focus of the interviews.

[58] One woman described her marriage as 'arranged' and not forced, even though it was against her will. Instead, she recounted the pressure that her mother was under. This may exemplify women protecting their families and not acknowledging that what they experienced was not right. Since 2007, forced marriages are unlawful under the Forced Marriage (Civil Protection) Act 2007 (https://www.legislation.gov.uk/ukpga/2007/20/contents).

met her husband immediately after arrival in England. Only one woman had experienced ongoing abuse in the country of origin, which then escalated after migration to England.

Having described the participants' characteristics and women's DVA experiences, I will now present my findings represented in my two overarching themes: *seen but not heard* and *finding a voice*.

5.2 Seen but not heard

I will start with a general overview of my first overarching theme, before describing its respective themes and sub-themes in more detail. Here I will provide supporting data from both migrant women and professionals.

> *Not only the abuse was horrible but what's also horrible is people not understanding you, you know you feel alone, and you felt like nobody is helping you, you are screaming but nobody can hear you.*
>
> *Aisha, from Somalia*

My first overarching theme *seen but not heard* represents the idea that although migrant women accessed healthcare[59] and other services, women felt unheard or seldom heard due to several factors: they were silenced through coercive control, threats of deportation and killings, fear of the consequences of disclosure (e.g. disrupting social networks), or lack of knowledge; women were often unable to make the link between DVA and mental health, which was often stigmatised; and they experienced language barriers and inadequate healthcare responses.

5.2.1 Coercive control: Don't speak!

Coercive control affected all migrant women and silenced them to differing degrees. Some women's movements were severely controlled, which also extended to the healthcare setting where many women were accompanied by their husbands. For instance, after beating Nana unconscious, Nana's husband brought her into hospital. When the hospital staff asked Nana about what happened, her husband was also present, which prevented disclosure.

> *Yeah, when I got up from bed unconscious and I got up, the nurse said 'Nana, from your husband, your husband said you fell from the stairs', I didn't say yes, at the moment, I think about it, but he was there, so I said yes, I did. Yeah.*
>
> *Nana, from Ivory Coast*

Asking Nana about the incident in the presence of the husband was unsafe, which was also stressed by professionals working for DVA organisations or healthcare. Yet in the case of

[59] Some migrant women were heard in healthcare (which will be covered in *finding a voice)*; however, there were challenges to being heard, for which reason *seldom heard* may be more appropriate.

migrant women, coercive control may be carried out by multiple people, such as the wider family, which can make it impossible to speak to these women as an independent domestic violence advisor (IDVA) working in a hospital observed:

> *[…] seeing them [the women] here [in hospital] sometimes can be a challenge that if they have multiple perpetrators we have had victims and patients actually that we couldn't see because they were being observed erm to such an extent that you know it was difficult for us to go and speak to them.*
>
> *Nina, IDVA, hospital*

This highlights that help-seeking and provision of help for migrant women are additionally constrained by a multiplicity of perpetrators and extended into healthcare settings, which if not recognised by professionals, may endanger these women. These women could not be reached despite having an IDVA working in the hospital, which emphasises the need for also helping these women.

The women's social network was often unsupportive and responsible for introducing or reaffirming feelings of shame and guilt and silencing DVA. Four women first disclosed to their family or family-in-law. However, these women were either consequently pressured into staying or the family could not help. As previously mentioned, Aisha from Somalia described how the wider social context, including her family, contributed to being '*seen but not heard*'. Similar pressures were experienced by Nana. Nana's social network advised her not to call the police as this, they argued, would impact Nana's child's wellbeing negatively – even though Nana encountered severe physical abuse by her husband (e.g. being stabbed with a knife and beaten unconscious). Nana's unsupportive social network confirmed Nana's belief that there was no help available.

One woman[60] was distressed about her childless and abusive marriage, but felt she had to be 'silent' about these family matters. The DVA, constant questions, pressure and blame from both sides of the family for not being able to bear children affected her health.

> *'Why don't you have kids, why don't you have a family,' you know, 'you're not responsible and have to take care of your husband'. They started blaming me and they didn't know what the problem is. So, I had a lot of health problems, and I collapsed many times.*

This quote also represents an explicit prescription of subservient gender roles, whereby a married woman is supposed to become a mother and carer of husband.

[60] To protect the anonymity of my participants, some of the identifier have been removed.

5.2.2 Fear of consequences of disclosure: Can't speak

The fear of consequences of disclosure of DVA constrained help-seeking, which was identified by both women and professionals as the major barrier. This fear was often instilled by the perpetrator(s) and closely tied to the fear of breach of confidentiality:

> *When I came to this country, he scared me a lot, because he said if you go out they'll ask you for your papers, when you go to the GP they will ask you for the passport […] So, I'm scared to tell somebody that blah, blah, because I know they will take me back or what to arrest me and put me into prison, so we are scared, so it is very difficult for us to say our opinion, our mind.*
>
> *Nana, from Ivory Coast*

Nana lived in the UK without any residency status. Her husband had induced and maintained the fear of deportation in Nana and, moreover, threatened to kill both her and their child if Nana ever disclosed. Interestingly, Nana changed perspective to cover other women in her position (e.g. '*I'm scared*' became '*we are scared*'). Professionals concurred that perpetrators deliberately threaten women about the potential negative consequences of disclosure:

> *A lot of what the perpetrator might have told them that they would be deported back to their country, that they wouldn't be able to get any help, they would be homeless, x, y and z.*
>
> *Nina, IDVA, working in hospital*

These consequences were not unfounded, as separation could often cause loss of immigration status and financial support – particularly when migrant women had no recourse to public funds (NRPF)[61]. This was also commented on by the IDVA. A Polish healthcare professional reported that Polish women's greatest concern was being '*left on their own*' and then having to '*sleep rough with their children*'.

Consequently, this dependence can make disclosure and separation extremely difficult for migrant women, who reported being ostracised by the community and shamed for divorcing. For example, Aisha had to change schools because her children were bullied after separation.

> *I was feeling a lot of pressure outside, even my kids was feeling if they go to school, oh his mother, that… don't go near her…him because of their mother. And the women, especially Somalia women, being told not to come near me. […] but I stood my grounds I said okay let them do whatever the hell they are doing, so it was a rough ride and I have to move away from the area I live!*
>
> *Aisha, from Somalia*

[61] While some migrant women may have a residence permit that allows them to live in the UK (e.g. from the EU), they may have 'no recourse to public funds'. This means that these women are unable to claim most benefits, tax credits or housing assistance that are paid by the state.

Aisha was told that by involving the police and divorcing her husband she '*became white, British*' and brought shame upon her family. This also affected her identity, in that she became a single mother and an outsider in her community, which she and her children had no choice but eventually come to terms with. Such experiences were also reported by professionals. This was even more difficult when migrant women feared being disowned by their own sons and could not speak English.

> *[…] she says I can't I would leave my whole community I would leave, I don't speak any English, I would leave my sons, my sons wouldn't speak to me again.*
>
> *Frances Long, HCP, England*

In instances where marriages had taken place between cousins, separation could also cause '*wider repercussions*', disruptions and conflict within broader family relationships (e.g. between siblings). Thus, separation may be harder for migrant women due to the multiple legal, financial and social repercussions they may face – although healthcare professionals may not be aware of this.

5.2.3 Silenced by lack of knowledge and stigma: Can't speak

Women were silenced by their lack of knowledge about what constitutes DVA. This was partly due to coercive control, lack of language as well as women's limited social contacts. Several professionals maintained that information about DVA and sources of help did not enter close-knit communities. Not perceiving the experienced violence as DVA and lack of knowledge of laws against it, as well as the role of support agencies, made it difficult to raise and disclose DVA in healthcare and beyond.

> *[…] domestic abuse is not impressed [author's note – interpreted as meaning expressed/spoken about] at all in my culture, in my country and we don't know it I think we don't talk about it, we don't highlight it because we don't know what it is and when I came here as a wife, I wasn't aware that my life is going to be in that form […]*
>
> *Mariam, from Sudan*

The above quote also indicates the onset ('*when I came here as a wife*') and dismay of experiencing this. It was important to understand how migrant women perceived DVA by listening to them first, rather than imposing any *ready-made definitions* to find out how to support these women best.

> *[…] there is a lot of taboos and cultural barriers for people trying to understand what violence is. Sometimes domestic violence, what you mean by domestic violence may be a term new to migrant women and there is a lot of cultural influence to that as well. How can they interpret that?*
>
> *Ahmad, HCP, from Sudan*

Ahmad also specifies that the term 'domestic violence' is too complicated and abstract to understand, particularly for non-native English speakers. Lack of knowledge and

understanding of DVA was also echoed by other professionals, who said that women were '*not aware what abuse consists of*'. Professionals further maintained that migrant women from Poland would not recognise '*any kind of pre-marital rape or connection to sex*', or coercive control, including not being allowed to learn English, as DVA. Psychological violence was particularly not recognised as DVA, as the quote below illustrates. Here, the only reference point was severe physical abuse that Lina witnessed between her parents, making her think that her own relationship was '*brilliant*'.

> *I always felt there was something wrong, but I didn't know exactly what's wrong. Because all the examples I could have it was my mum's relation, which was extremely violent and blood jumping out of her head and things like this, me going with her to emergencies, um, because that was the situation at that point. So, I always saw my own relation with my ex-partner, um, as being brilliant comparing with my mum's relationship.*
>
> *Lina, from Romania*

However, other professionals maintained that recognising psychological abuse was generally difficult for non-migrant women, too.

The cultural dimension of DVA was echoed by various professionals, including professionals who had either migrated themselves to the UK or whose parents had migrated (see Table 5.2). While professionals were careful to differentiate between different migrant women and not to generalise these women's experiences, there still appeared to be two cultural narratives regarding both violence and silence: a) migrant women were affected by more (normalised) violence and were more silent or b) they encountered more (normalised) violence but were less silent. This applied to migrant women themselves and other members of their community, who partly acknowledged this violence more openly when perhaps compared to mainstream British people (where it might be an equally present issue but less talked about). However, it is not known whether this acknowledgement was part of the cultural normalisation or misappropriation or individual.

> *Our impression is, and from obviously living with lots of people from all different cultures is that in some cultures, actually, it's not such a massive taboo and it is, felt a bit more widely, to you know … That if you hit your wife the odd time then that's okay, amongst some people, but I'm not making any generalisations whatsoever, but it is, I think that's the case sometimes, you know like some of their, erm, Iranian men that I've lived with you know thought that you know the odd time you know as long as it wasn't too hard, it's alright. Whereas I don't think there's many English people that would say, would admit to saying that you know. So, I think it is, there's that.*
>
> *HCP*

Although DVA was still considered a taboo, another HCP, noted a differential cultural openness (or cultural suppression) in diverse migrant women when disclosing DVA. While not working directly with migrant women, he had become aware that DVA was a problem in the Polish community, despite Polish women only having migrated to the UK more

recently than other migrant groups (e.g. Somalian, Afghan and Asian migrant communities living in the UK for decades). He postulated that these other migrant communities had only recently become more open about DVA and was curious as to whether his insight indeed matched with DVA police reports and statistics. He tentatively attributed this to Polish women's European heritage, which potentially made them more likely to disclose, as well as the alcohol use in Polish communities. Although his perception is partly at odds with women's and other professionals' accounts, it may indicate that the pressure to remain silent is, perhaps, even greater in some migrant communities. At the same time, he and others pointed out a lack of information about DVA and sources of help in these communities, which were hard to penetrate.

Women often extrapolated their country of origin's responses and laws (or lack thereof) to DVA and anticipated similar responses in the UK. Even when there was some awareness regarding violence, this was surrounded by normalised perceptions of DVA and rendered invisible in the UK: Maria from Ukraine saw DVA as 'private', which should be dealt with within the family only: '*Oh I not told doctor that I had got arguments all the time at home, it was family business'*. Thus, the perception about DVA also shaped women's healthcare expectations and behaviour. This was echoed by one African woman, who recalled her historic abuse and said that, at that time, she was unaware that she could have asked her GP for help or contacted a DVA organisation:

> *[…] you got no way out, so I didn't know there was' [name of DVA organisation]' or other help, or even GP help, I didn't know that.*

She further indicated that Somali women still do not think that DVA can be raised in healthcare.

During her abusive relationship, Aisha had given birth in Britain; it is, therefore, highly likely that she had engaged with health services, such as antenatal care (e.g. with midwives and health visitors) during that period. However, this was before DVA training and antenatal screening were introduced. Thus, the abuse Aisha encountered may not have been recognised due to lack of training and professionals would, therefore, not have asked or helped Aisha. However, there remains a lack of awareness that DVA could be raised within healthcare, particularly with a GP. For these women, DVA is perceived as something private and not a valid healthcare matter. For instance, as recounted by a Polish HCP:

> *I don't think they see healthcare system as a point of contact for domestic violence […] because you wouldn't seek help for domestic violence from your GP in Poland.*
>
> *Stefania, HCP, from Poland*

This extrapolation of country of origin cultural norms is therefore not limited to African, or Asian cultures, it also affects Central and Eastern European cultures. It is possible that there is an indication of a more global subculture attached to DVA, but that is sadly beyond the scope of this study. Language barriers and stigma made disclosure more difficult, which will be explained next.

5.2.3.1 Not making and communicating the link: *'All I have is stress'*

All migrant women suffered from a variety of health problems caused by DVA, such as stress, injuries and depression. However, women seldom sought healthcare for these problems; instead, they predominantly sought healthcare for their children, fertility or postnatal issues, or the medical or psychosomatic symptoms of their abuse. Women seldom made the link between DVA and their/their children's (mental) health problems; this was partly due to lack of knowledge about mental health issues, stigma related to these and language barriers.

Aisha observed that Somali migrant women often did not make the link between DVA, the violence experienced or witnessed in the Somalian civil war and their mental health. Instead, they communicated their psychological distress by focussing on their somatic symptoms.

> *'No, they don't because if they if they make the link they would have come out and ask for help. You know, all they know it's that they are aching, everyone is aching.*
>
> *Aisha, from Somalia*

Thus, some migrant women sought healthcare primarily for medication and Somali women also advised each other on medication, which Aisha thought to be dangerous. DVA professionals generally observed that there was a tendency toward long-term-prescription, which also applied to non-migrant women affected by DVA. Aisha was concerned about the long-term health consequences of this and questioned whether the emphasis of medication reflects an economic rationale from the side of healthcare, whereby it is cheaper to prescribe medication rather than provide therapy for depression, which she considered crucial in addressing the underlying cause.

> *see a woman who said I've been having this [...] sleeping tablet for 5 years. I said, 'why?' She said it makes me sleep. I said 'so what has your GP said about it?' She says, 'if it makes you feel better so keep having it'. But it has got a lot of side effects and... 5 years, and she goes if I don't have it then I am not going to sleep so I have to have it. It scares me, she's got young kids. So, what's going to happen if kidney failure happen or liver failure happen. Or. GP knows best, but anyway in my head... It's not good. I can see she's depressed, I can see if she had therapy she would have dropped these tablets. But I don't know which is cheaper, is it money, I don't know.*
>
> *Aisha, from Somalia*

The focus on physical symptoms was echoed by various professionals, who noted that women downplayed their feelings and attributed this to general life stressors *('life is tough, and I have to deal with it'*), even when they were aware that something was not right. An HCP also reported that Somali migrant women often sought help for their physical symptoms and therefore expected a '*physical solution*', rather than revealing their emotional distress. The HCP attributed this to using a different health paradigm, as well as the stigma surrounding mental health issues.

> *Lots of the white patients who are coming in, they're straightaway, too quickly if anything, saying I'm depressed I've got a depression doctor, it's my depression and whereas for some of the patients from BME communities, I suppose particularly Somalia, they wouldn't say that, it would come out as a physical symptom or there's, erm, so there's an understanding issue or a different models of health but also stigma for some people around certain health problems causes issues. So, for people with HIV or erm, mental health problems, and things like that, that's an issue.*
>
> *Frances Long, HCP, England*

The stigma of mental health may result in denial and silence, as women fear being perceived as 'crazy', which is socially unacceptable. Being affected by DVA and/or mental health problems therefore represents a twofold taboo that was suppressed ('*put underground*'). This denial was particularly evident when suggesting to women to talk about these issues. Aisha partly related this to having to adapt to many changes after migration, such as a new culture; in effect, women do not have the mental space or time to deal with the experienced violence (either in the home and/or during the political conflict in Somalia), let alone voice them. This also indicates anxiety and lack of familiarity with the range of healthcare services, where mental health issues can be raised. They feared that this would make them seem '*crazy*'.

> *If you say go counselling or talk to somebody, one will go do I need to talk to somebody. Anything with the mental health is a taboo, same as domestic. So…*
>
> *INT: Two taboos then.*
>
> *RES: Yeah, it's bloody taboo to put this underground because it's, it's a new culture, everything is new. So they are not saying well, (pause) 'I am feeling sad' or 'I am feeling low', […] they are not going to come to the GP and ask that, but they will just, if you say, 'may, you thinking too much and you, you need to talk to GP, talk about what's going in you, that's what I have to do', 'I am not crazy'.*
>
> *Aisha, from Somalia*

This denial of DV's impact on mental health was also evident during the interview, as there were some contradictory descriptions of how migrant women described their own mental health – such as 'fine', 'healthy' or just 'stressed', even though they also recounted depression, long episodes of crying, panic attacks, anxiety, suicidal thoughts and PTSD

symptoms. It is possible that this denial seen in migrant women may be a protective mechanism against feelings of vulnerability.

Lina attributed not being able to make the link to lack of knowledge about depression. Recognising this decline in mental health and linking it with depression and DVA requires a professional, who helps establish this link and provides an explanation:

> *[…]that's when professionals when they get involved help them to make that link as well, […]. They know what they're feeling but they can't label it until somebody else gives it a label or defines it. It's their feelings. They're feeling this. I feel this, I feel … and then when you say … when somebody listens to them and defines it for them, then that gives them that reassurance that, oh, it's because of this Domestic Violence, that's what all women feel, that's what all women go through.*
>
> *Sara, professional in the DVA sector, Pakistani origin*

This quote shows that professionals are important in recognising the women's decline. This is done by listening and helping women to label their own feelings (e.g. depression). By doing so, professionals validate, normalise and destigmatise women's feelings and DVA experiences by reassuring them that these feelings are a normal reaction to DVA. It is noteworthy that this professional was not a medically trained person but is responsible for wider needs within the DVA organisation.

5.2.3.2 Language barriers

Not being able to label depression may also be caused by language barriers. In Western society, talking about 'being depressed' or 'depression' may have slipped into every day-use, as indicated in the quote by an HCP earlier, although this does not mean that depression is less stigmatised. However, this medical term may not be commonly used by migrant women due to lack of English proficiency and describing mental health problems may be made more difficult as poor mental health may have a silencing effect (by, for instance, causing withdrawal and not being able to express these feelings). Lina experienced this due to being '*in such a muddle of feelings, and none of them were good*', which were exacerbated by language barriers. Lina felt it hard to describe her feelings in English: '*because when it comes to these things, I don't even know how to say them in English because I'm not used to the terms. I describe it in my own way*'.

Lina was eventually diagnosed with depression, although she was not asked questions about her feelings and did not receive any information about her diagnosis and medication. As a result, Lina felt rushed and not appropriately treated, leaving the consultation with only a prescription.

> *[…]. She was ever so quick and, um, she wouldn't ask me too much, and, um, it was like I was going there only for her to write some papers for me and to prescribe and that's it.*

Lina, from Romania

Not receiving any explanation for the prescription caused Lina anxiety and made her feel like a '*freak*': Lina hid her antidepressants in the house and feared that the parents of her children's friends might find out about her depression and would consequently perceive her as unfit to look after their children or would stop speaking with her. This indicates that Lina felt unable to talk about her diagnosis with anyone in her social network as she feared being ostracised.

> *It was ever so hard to face that tiny tablet and I didn't really want my daughter to see it. I mean when I … when the pharmacist handed it over, when the chemist handed over the medicine, I was like totally (pause) not being able to recognise myself. I was thinking, 'Oh, am I ever that bad, oh am I ever going to be back to the same person, which I've been. Um, I can't really speak with anyone about this because I'm feeling embarrassed and, um, they will feel I'm a freak, and they won't want to speak with me.*
>
> *Lina, from Romania*

Language barriers may also impact understanding and knowledge of the diagnosis and prescribed medication: Many migrant women did not know the medication (often multiple drugs) they were taking and what this medication was for. DVA professionals could not help, as they were not medically trained ('*I'm not going to give advice because I'm not a healthcare professional'*). There was a lack of information about depression in languages other than English:

> *When you prescribe anti-depressants, for example, this pop-up information comes so again it's something that I'm reflecting on as I'm speaking to you but it's all in English so perhaps it would be helpful if that written information was in different languages because we don't have it at the moment and also, it's full of resources and online resources and things, which are all English as well.*
>
> *Frances Long, HCP, England*

Mariam confirmed that this written information in English would be inaccessible for many migrant women, particularly if they were uneducated, distressed and had to look after their children. At the same time, Mariam pointed out that a translated leaflet would be insufficient, as migrant women often required more help and instructions.

> *[…] if there is a lack of instruction and there is a lack of understanding for this kind of information in the language that it's written it would be much more harder. Definitely this, you know, simple woman with two kids she would not take all the hassle and challenge to read to interpret and translate this piece of information, it would be very hard for her.*
>
> *Mariam, from Sudan*

Hence, alongside stigma, language was a barrier in healthcare and beyond. Migrant women appear to need more support rather than receiving only a leaflet about depression and available services. Even if information is translated into migrant women's first language it will not reach illiterate migrant women.

5.2.4 Inadequate language provision: Can't speak

Language barriers undermined or interfered with direct communication, for instance, when describing symptoms, receiving a diagnosis and medication.

Language barriers also seemed to reinforce and exacerbate coercive control: three women did not have the chance of speaking to their HCPs without their husbands, who acted as their interpreters, because the women could not speak any or only very little English. Here, lack of language was used by the perpetrators as an additional layer of control to further restrain the healthcare consultation. In the following quote, the frustration and desperation of not being able to directly communicate is clear from both Fatima's and the doctor's side. While the doctor attempted to ask Fatima questions, these were not translated by Fatima's husband–maintaining that he had previously discussed all this with Fatima. This infuriated both Fatima and the doctor and left them both feeling helpless in the absence of an interpreter.

> *He bring me, to like erm a ... like a midwife and health visitor, he bring me there. He's all the time translation and he go with me to the doctor, translation and even when I be ill he go with me, he say what his want, not what I'm feeling [...] he asked and he answer interpret for me, and translation for me and he take what answer, she and he is answer, don't ask me, I' there, but he don't ask me anything. She tell me, 'why is she here then?', 'why do you answer for everything?' [the husband replied] 'because I know what she is saying before we come here, I ask her about everything' that's why I am say no, she [the doctor] be very angry [with] him.*
>
> *Fatima, from Libya*

Fatima would have welcomed being able to speak via an interpreter without her husband, yet she had never been offered this. This is a failed healthcare response, which further silences migrant women. Various professionals identified language barriers and not being able to speak to the women on their own as a major barrier to communication about DVA. The reluctance to use professional interpreters was also based on the healthcare professionals' fear of offending the husbands or other family members:

> *I think practitioners have found it quite hard to actually say well actually you know we'd rather use a professional interpreter, erm, for you know risk of kind of offending that person.*
>
> *Lucy, DVA professional*

Fatima and Marta from Brazil also noted that their healthcare professionals were manipulated by their husbands: in healthcare consultations, their husbands often acted loving and caring and engaged in small talk – even joked – with their healthcare professionals. This further concealed DVA and may have made it more difficult for healthcare professionals to insist on using interpreters.

Apart from concealing DVA, language barriers also gave the perpetrator the power to influence the woman's diagnosis and treatment. Marta experienced DVA from her mother-in-law, which instigated marital disharmony and led to Marta becoming depressed. Marta's HV suspected this and referred Marta to her GP. However, in these healthcare consultations, because of not speaking English, Marta believes that her husband attributed Marta's depression to having given birth. This led Marta to being treated for postnatal depression with antidepressants. The underlying reason for her depression was never investigated.

> *My husband said I don't know why she's sad, because she's...er...she's got a baby now. And come to the doctor, my husband always talked to me, I never talk nothing, that's why, I never talk, I don't know exactly what she's asked to him.*
>
> *Marta, from Brazil*

Stefania observed that some GPs still did not use interpreters. Due to lack of resources, interpreters were not available in all healthcare and other settings. There were also problems of obtaining interpreters for certain languages and this increased waiting times; if not successful, consequently preventing healthcare access and the opportunity to disclose.

5.2.3.3 Time constraints exacerbate language barriers: missed opportunities

Language barriers were exacerbated by these time constraints and impeded communication: Somali women were very self-conscious because of their accents and if they felt rushed, they lost all their confidence and fell silent.

> *[...] because we all got accent, isn't it? and they feel intimidated, like' [in louder voice imitating a/the GP] 'What, what did you say?' You know what I mean, it's just like how you understand. [...] But if you just say, 'Okay the other patients are waiting, so how can I help you?' Well it's this lady is not even speaking proper English, you know. All the things, oh just go away. Then you will shut down. Does that make sense?*
>
> *INT: Yes. She is not being heard?*
>
> *RES: She is not being heard. So, because she'll shut up, because she is erm, not good, not feeling good she keep come back, because this is her hope and then she will be at the GP's door 8'o'clock in the morning and so waste for the GPs time and for this lady's time and nobody is getting better you see.*
>
> *Aisha, from Somalia*

This quote suggests that when healthcare professionals raised their voice when repeating (or asking) a question, this was perceived by Somali women as intimidating. It does not seem to reflect a sensitive and respectful approach when dealing with patients whose first language is not English. Aisha stressed the ineffectiveness of this healthcare response, which led to frustration on both sides and repeat visits without any progress. If DVA and mental health needs problems are silenced or not understood in healthcare, they often

remain unaddressed. This represents missed opportunities and increases the likelihood of mental health problems becoming chronic.

Out of eight women, Lina was the only one who tried to proactively speak with both her HV and GP about problems related to DVA. In a consultation shortly after arriving in the UK, Lina felt unheard and not understood by her GP when she told him that she felt unwell. Instead, Lina felt rushed, ignored and not taken seriously when her GP insisted that she was fine: '*He said, 'No, no, no, you are feeling very well.' He did this to me, I don't know how to say it, 'Go home now, you are feeling well,' and that's it! (Pause)'*. The difficulties of verbalising mental distress have already been described and these are exacerbated by language barriers and time constraints.

Women affected by DVA and various professionals alike maintained that time constraints were barriers to building trust, rapport and, hence, disclosure. In the following quote, it seems evident that asking direct questions about stigmatised subjects, such as sexual violence and mental health, in a quick healthcare encounter in the emergency setting does not always inspire enough trust in women.

> *[…] from someone booking into the department to being discharged four hours, to being registered and seen and treated, this is time constraints and so a service such as ours, being able to slot in and saying, 'you don't know me but please trust me and tell me very private things about your life', sometimes we're asking from the risk indicator checklist about sexual violence, about mental health, etc, etc. So, you are having to do really quick level of engagement in getting that person to trust you to be able to then move on and sometimes for whatever reason that doesn't happen […]*
>
> *Nina, IDVA in hospital*

5.2.3.4 Inappropriate and unsafe interpreting: barrier to open communication

Providing expert interpreters was not a straightforward process and using interpreters could interfere with open communication about DVA, as it could interfere with building rapport: '*Erm, that does feel like it puts a bit more of a distance between you and the person who's there*' (Emma, DVA sector). This could therefore make disclosure more difficult. Using interpreters also delayed the interaction and prolonged conversations:

> *there's a delay in that interaction as a sort of a time lag*
>
> *Emily, professional in the DV sector*

Diverse professionals reported experiences where migrant women had requested interpreters from a different city because they feared that interpreters could recognise them and breach confidentiality. There were mixed opinions regarding the use of telephone interpreting: while it increased anonymity, it did not always inspire trust. As noted by one HCP, when using interpreting in consultations in primary care, confidentiality was not

explained due to time constraints. Yet such explanations may be needed for trust or reassurance.

Inappropriate and inadequate interpreting was also raised; for instance, using a male interpreter was perceived as inappropriate in terms of gender incongruity between the migrant woman and the DV professional. There were also examples of inadequate interpreting when the answers did not reflect the questions asked by the HCPs:

> *I have had GPs say you know 'we asked about where there were difficulties in their relationship with their partner' and erm, I think the answer was, 'no, they're not married' and that wasn't what they were asking, so yeah, it's, you know that's not particularly helpful.*
>
> *Lily, working for a DVA organisation, England*

It is unknown how HCPs addressed this in their consultations, whether they probed further or stopped asking. This shows that enquiring about DVA was impeded by using an interpreter who may have felt uncomfortable by the question.

Coercive control and violence by the perpetrator could extend to making the interpreter feel threatened: Stefania interpreted in the home of an abused Polish woman, where the perpetrator was often present, which made Stefania feel very unsafe. Stefania worried that the perpetrator might be able to track her and harm her and/or her children. As a result, she refrained from further interpreting.

> *when I started interpreting, I was involved in interpreting for a family, for a woman who experienced domestic violence and it was such a difficult, um, experience, for me that I withdrew. I refused to go there anymore because, er, because of what the woman was saying and also, um, (pause) I didn't feel safe there because her husband was very often present at um the house.*
>
> *Stefania, HCP, from Poland*

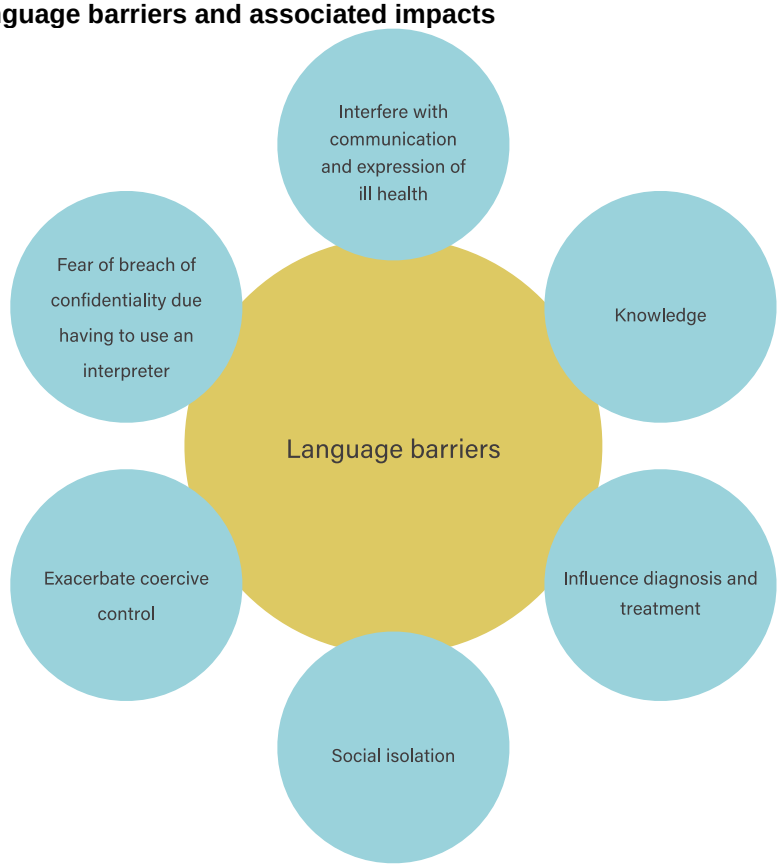
Thus, while home visits with interpreters may be more accessible to migrant women and may help with disclosure, the home needs to be a safe environment. Communication between Stefania and the professional about Stefania's feelings of being threatened may have made it possible to safely continue interpreting for the Polish woman in a different setting. Consequently, even when interpreting is provided, it must be ensured that it takes place in a safe setting for all parties involved. Due to fear of breach of confidentiality, Stefania also reported that some Polish women requested interpreters from a different city or town.

5.2.4 Summary, 'seen but not heard'

My first overarching theme '*seen but not heard*' incorporates themes, such as coercive control, fear of consequences of disclosure, silenced by lack of knowledge and stigma,

language barriers and an inadequate healthcare response – all of which explained why migrant women remained unheard in healthcare. Although I have identified different subthemes, my analysis illustrates their intersection; that is, themes and subthemes were closely intertwined, overlapped and exerted a multiplying silencing effect. For instance, language barriers resulted in a lack of knowledge and in inadequate healthcare provision. Figure 5.2 below shows the multiple, often overlapping areas affected by language barriers.

Figure 5.2: Language barriers and associated impacts

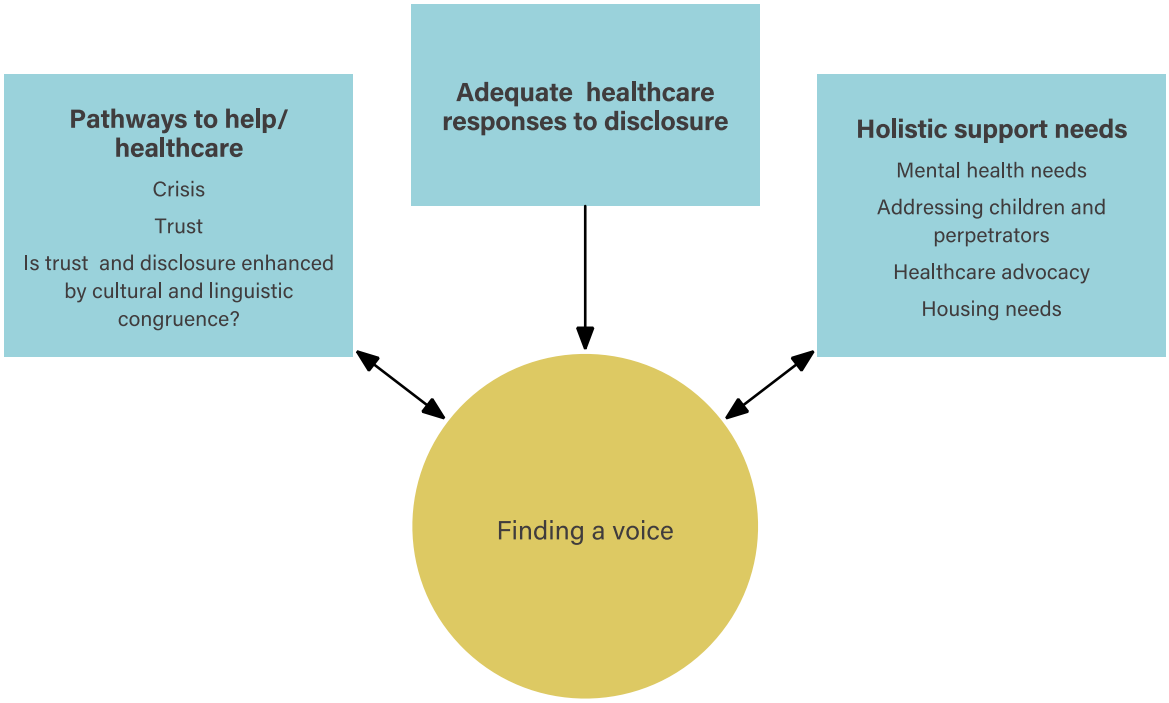


I will now explain how migrant women found their voice.

5.3 Finding a voice

My second overarching theme *finding a voice* (see Figure 5.3 below) comprises the following themes: 'pathways to help/healthcare', with the subthemes 'crisis' as the main trigger and 'trust' as the main condition for disclosure; 'adequate healthcare response' and 'holistic healthcare support needs after separation'. I will particularly discuss whether migrant women desire a culturally congruent healthcare professional (i.e. from the same country/culture) in the context of DVA disclosure.

Figure 5.3: Finding a voice



5.3.1 Pathways to help/healthcare

This theme addresses the second of my research objectives; namely, it captures how migrant women with histories of DVA found support. There were four different pathways to help/healthcare, mostly triggered by a crisis. This crisis was caused by the severity of violence and its (mental) health impact on the women and their children. Here, the point in time when healthcare was accessed for DVA differed, if it was accessed.

5.3.1.1 Crisis

When in crisis, some women disclosed to trusted individuals, who then encouraged them to contact or connected them with healthcare and other supporting services (pathway 1). The severity of DVA and its resulting facial injuries led one woman to disclose to a concerned employer, who then advised her to disclose the violence in healthcare. Another woman was so unhappy about her abusive marriage that she wanted to commit suicide; only then she disclosed to a friend who put her in touch with DVA services. The severity of DVA and its impact on children also resulted in disclosure; three women (eventually) realised that they were affected by DVA and that this would make their daughters believe that DVA was normal and one, therefore, disclosed to a professional they knew. For another

woman, the imminent danger of being separated from her children[62] triggered disclosure to an acquaintance.

A few women encountered violence by their husband and/or by their family in-law, which led to disclosure to the police (pathway 2). For instance, one woman was physically assaulted by her husbands' family and had to defend herself; due to accusations by her husband and his family, however, as well as the woman's lack of English, she ended up being arrested as the perpetrator. A failure of safeguarding was evident in two cases; here, women either stayed or returned to their homes because their children were still with their husbands and these women had nowhere else to go. This led to verbal abuse and threats by their husbands. One woman was also physically assaulted by her husband. To keep safe, both women locked themselves into their children's bedrooms. Marta was not referred to any other sources of support and telephoned her HV, as this was the only helpful number she could find. The HV advised Marta to leave immediately and later connected her with DVA services.

> *I saw, in my kid's red book, I saw the health visitor number. I said, 'I need help, I can't stay like this, because I'm very scared.' I said, 'Can you do something because my father in-law says I will kill you, you bitch. My husband tried …To strangle me. They said (health visitor) 'Take the kids, go away'.*
>
> *Marta, from Brazil*

Only one woman disclosed directly to healthcare by phoning '111' when she was almost hit by her husband and her daughter intervened (pathway 3). Lina was motivated by her concern that her daughter would think that DVA was acceptable and this prompted her to directly contact healthcare.

Diverse professionals reported these often indirect routes (pathways 1,2) via trusted individuals or the police or nurseries, among other services, but also reported direct disclosures in healthcare (pathway 3). There were also some self-referrals[63] to DVA organisations (pathway 4), where women directly contacted these services. However, it is unclear how women had found out about these organisations and there may therefore be an overlap due to signposting with the other pathways.

> *But sometimes, when they're just so desperate … that they feel … I think quite often women do tend to disclose a lot initially to health visitors. We have a lot of referrals from health visitors or schools, like nurseries. We also have a lot of self-referrals. Maybe they've seen*

[62] This woman had been previously separated from her children for months without any contact when left in her country of origin, while her husband and the children returned to the UK. This separation was enabled due to an expiring immigration status (visa) as her husband had not renewed or changed it. This required leaving the UK for a period and her husband used this as an excuse for a 'family holiday'.
[63] Previous frontline DVA workers reported that migrant women had first disclosed to them. These disclosures were considered more difficult for the women as DVA had not been identified by someone else first.

the number at the GP surgery, and they'll ring up, or somebody's told them, and they'll ring up, word of mouth [...]

Sara, DVA professional, of Pakistani descent

A few DVA professionals worked closely with HCPs in primary or secondary care, where they trained these HCPs in recognising DVA and referring affected women and then received direct referrals from these HCPs. The professional based in the hospital's emergency department said that 24% of BME women[64] were identified in the hospital setting due to sustained injuries caused by DVA[65]. This identification was enabled by having IDVAs in the hospital setting and providing training to professionals. Thus, the severity of injury (as in the case of Nana) seems to determine what kind of healthcare was sought. Having a dedicated professional who provides DVA training to HCPs to identify and refer women, as well as having a dedicated person onsite or nearby improves identification and referral of affected women – yet the turnover of staff may interfere with recognition. (Nina)

Regardless of the referral pathway, many DVA professionals appreciated being able to meet women within the healthcare system (e.g. in GP practices), as migrant women could access these without raising any suspicion.

It's great having the GPs because we often book in the re-settlement team, we normally book rooms there, erm, to do assessments with our women and some of my women, it's not safe to visit them at home because the perpetrator is still around, or he knocks all the time. So, we book rooms at the GP, erm, which they do for free, which is absolutely amazing, because we wouldn't have anywhere confidential to meet our clients if it wasn't for the service that GPs provided. So that's really, really appreciated as well that we can do that. And they're always very accommodating, the GPs are, that's great.

Emma, DVA services

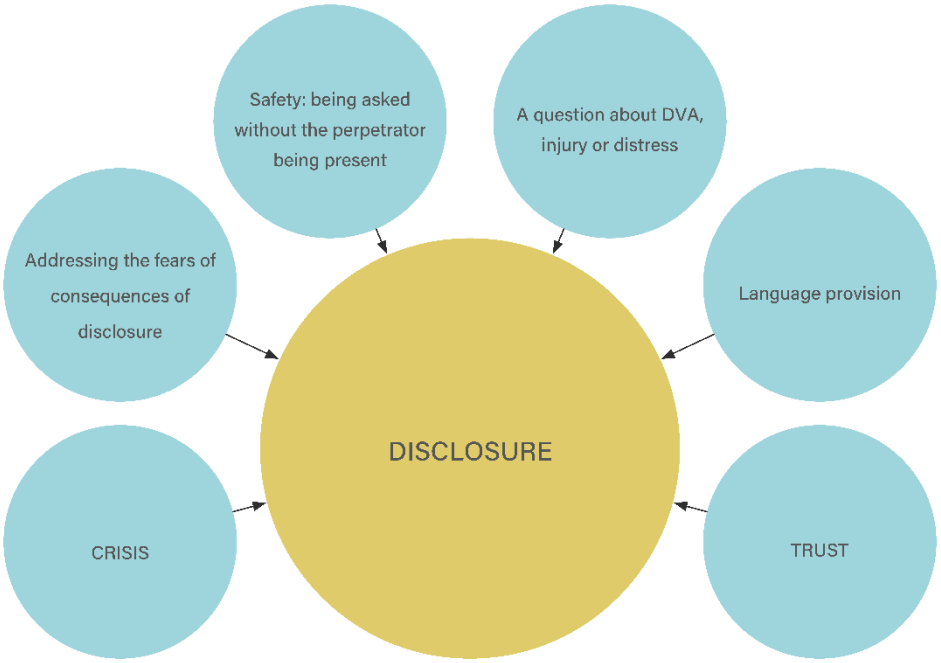
Having outlined the women's crises and pathways to help and healthcare, I will now describe the importance of trust, and other conditions, for disclosure.

5.3.1.2 Trust

Trust was identified by both women and professionals as paramount for disclosure. A question about the injuries or distress caused by DVA without the perpetrator being present enabled migrant women to disclose. Here, addressing the fears of women and adequate language provision were important conditions for disclosure (see Figure 5.4 below).

[64]The interviewee gave me a report/evaluation of their services, which also supported this number. However, despite this high rate of identification, many women were still not identified due to many reasons (e.g. time constraints).
[65] These women were often at a medium to high risk of being killed by their perpetrator(s) according to the IDVA.

Figure 5.4: Pathways to help/healthcare



Key: Capitalised text signifies that these were the prime trigger or condition for disclosure.

The following quote exemplifies the importance of trust and other elements for disclosure. Time was an important element for Nana in trusting the 'white lady' she cleaned for. This lady had shown concern for Nana by asking her about her facial injuries, which led to disclosure. This 'white lady' validated Nana's DVA experience, maintained that Nana's husband was in the wrong and addressed Nana's fears about the consequences of disclosure (i.e. being deported), reassuring Nana that this was not going to happen. This was crucial information and support.

> *Before I trusted the nurse it's like my friend, my white lady, she told me because I trusted her and I'd been staying with her for some time and she know I have a little child and so she was like 'Nana from what you've told me you don't have papers', and I said 'yeah', and she said 'Don't think about papers, you were born, you born this child here. So, the child is British, and according to your story you have problems back home, so I don't think the British government will take you back home. I don't think, they are not stupid, they are here to help refugees and so it's like you are a refugee, you are an asylum seeker, it is only that the husband you have, that stupid husband of yours don't give you the right way. So maybe he has problems, he has to be arrested, but not you, because he lied to you and he is doing all these bad things to you, he has to be arrested, not you.'*
>
> *Nana, from Ivory Coast*

This lady further offered to call the police on Nana's behalf and advised Nana to disclose to her GP, which Nana then did. Unlike in the hospital, this conversation occurred in private, thereby again highlighting the importance of asking women about DVA in safety (i.e. away from the perpetrator).

The importance of being asked to facilitate disclosure is captured below. It also shows that despite having a trustful friendship, this was not enough to supersede one woman's silence imposed by her communities' practices. This was only overcome by extreme crisis – when one woman tried to commit suicide.

> *I think for the mentality of my community and myself, we won't talk unless we're asked. I mean from my experience I did not tell anybody till the time that I tried to kill myself, [...] I called my friend, she came along quickly, I said to her I tried to kill myself. She came within fifteen minutes, I don't know how she did that, but she started asking me, asking me, and she was shocked, when she was asking me, asking me. When she was asking me, I just told her everything, I don't know how I did that, but I did it. Over two years I did not try to talk to her at all, even though I trust her, and I love her from the bottom of my heart, but something told me to do that.*

Here the woman's faith stopped her from committing suicide and she telephoned her friend instead, who quickly came to help her.

This quote highlights that disclosure was not easy despite being directly asked about DVA by a trusted friend. The pressure to hide the despair was still great and the quote therefore captures the woman's surprise at having disclosed. This indicates that disclosure in response to direct questions about DVA requires *both* trust and crisis. In healthcare, this may require building trust first, followed by a more indirect and sensitive approach to enquire about DVA rather than tackling it directly – which may be met with resistance:

> *It takes a lot of time and people have to trust you [...] I find that you have to keep to somebody's agenda first [...] rather than straightaway saying, 'oh come on, who's beating you up?', because if you do that straightaway they just, they'll just go to another doctor [...]. So, I found if I tried to keep people onboard a little bit and say well okay you feel it's a physical problem so we're going to do some blood tests and we'll do the scan but if there is anything that you're worried about as a totally separate matter you know then and sometimes that works.*
>
> *Frances Long, HCP, England*

The above quote shows that the HCP usually approaches the topic by following a migrant woman's lead, including carrying out tests, to develop some rapport and trust (and not to impose one's own perception of the situation); then, gently suggesting to the women that she could speak about other issues rather than being blunt and direct.

There was agreement between women and professionals as to how 'trust' can be built. This was linked to factors including time, being understanding and sensitive, getting to know the women by asking questions and listening to their answers, demonstrating kindness by displaying congruent non-verbal behaviour, and showing empathy, and being honest and transparent with decision-making. These factors will be put into the context of the wider literature in my discussion chapter. The gaining of trust may be especially important for migrant women who speak no or little English, lack social support and are highly dependent

on the abuser; this makes them particularly vulnerable and in need of someone who they can trust.

> *Don't shy away asking questions, but you know a little bit of love I think, I don't know, kind […] it doesn't have to be a language, it's body language, no matter which language we speak or understand, if you really kind towards me your body will tell me, you know do you know what I mean? You don't have to say, be humble you know and talk to… not rushing [makes a noise] 'okay just go, but actually spending, I know time is expensive, but you are not going to get any better, you know the patient is not going to get any better by rushing it you know so spend a little time and see what's going on. It might be, come as emergency, tell them to make a proper appointment. And that proper appointment talk to them deeply and find out what is going on you know. […] You know as a doctor you have to you want to be effective I think, you know you want, you know, your patient get better and feel good you know so humanity, just don't… I know it's a job but see it, listen with your open heart.*
>
> *Aisha, from Somalia*

Aisha points out that migrant women may not be aware of the appointment system and the time constraints of consultations in the UK, particularly emergency appointments, which would require explanation. Thus, she suggested that, healthcare professionals could explain this to women and then arrange a follow-up appointment to speak in more detail. This would leave women feeling understood and cared for. Aisha also suggested having the initial consultation without a professional interpreter with the woman and then, if needed, asking the woman whether she would be comfortable involving an interpreter for the next consultation. This would reflect the HCP's desire to understand the woman better and involve her in the decision making.

5.3.1.3 Is trust and disclosure enhanced by cultural and linguistic congruence?

There was disagreement among women and professionals as to whether they a) perceived healthcare professionals, particularly GPs, as the appropriate professionals to disclose DVA to and b) whether HCPs had to be from the same country or culture (cultural congruency).

> *To be safe, a secret, because when you are scared from … you don't talk to friends, talk to doctor, the nurse or to the health visitor, I like very much the health visitor. They're like a…[friend] They hear you, they do everything, they try everything help you. I think the health visitor is the best. (laughs).*
>
> *Marta, from Brazil*

The above quote illustrates the fear of breach of confidentiality when disclosing to friends and the expected safety of talking to HCPs, who may be seen as more trustworthy. Marta emphasised that she felt heard and helped by her HV, who was *'the best'*. Marta had received significant support from her previous and current HV; however, not all women were so positive. Lina felt let down by her HV for not detecting DVA earlier.

Diverse DVA professionals stressed the pivotal role of HVs in identifying affected migrant women and referring them. According to one professional originally from Poland, this

applied not just to migrant woman, but also other non-migrant women affected by DVA, HVs were perceived as more of a family support person, who were approachable, visited them at home, were informally dressed and showed interest in their children – in contrast to GPs, who to women often seemed more formal:

> *I have worked in the past a lot with the health visitors and I think they are amazing, they are very often, at least with the Polish community, they very often were the first point of contact for the women who've been experiencing abuse, so the women that will not disclose this to the GP because they see him as, him sorry, they see that person is a very kind of formal person, but if they've got a health visitor coming, you know plain clothes, coming for a home visit, talking to them and being interested in the children, being very friendly being kind of, you know family support person, yeah? Then they do open up and we do get a lot of referrals from the health visitors.*
>
> *Barbara, DVA professional and interpreter, from Poland*

A Polish HCP observed that Polish women only talked to GPs when advised by trusted individuals (like in the case of Nana). An HCP maintained that if migrant women knew about DVA agencies, they would go to these organisations directly. One HCP also felt uneasy that GPs were sometimes used as a '*sign poster to all kinds of problems*' that were not necessarily perceived as strictly medical, including DVA. However, some women may be advised to consult a GP to obtain medical evidence of their injuries; DVA organisations may be stigmatised and, thus, require an external other to act as a door opener.

There were discrepant views regarding whether (or not) migrant women required HCPs or other professionals to also be from their countries of origin or for them to be culturally sensitive. As discussed earlier, narratives from women from African countries (both Christian and Muslim) seemed to reveal a deep-seated mistrust of people from the same country, including HCPs, who they feared would judge them and not treat their disclosure confidentially.

> *It's that trust that we don't have, we don't have that trust, especially when it comes to an African community, they don't trust each other.*
>
> *Nana, from Ivory Coast*

This fear was also echoed by Mariam. Mariam believed that HCPs who were not from the same country were more trustworthy than friends because they would not know her and not talk behind her back. Thus, a woman would be more likely to disclose to such HCPs:

> *she would think about her GPs because she believe her GP does not know her. She does not know her community, she cannot talk beside and in that case, she can open up.*
>
> *Mariam, from Sudan*

Mariam refers here to a female GP, perhaps implicitly indicating that gender congruence may be a relevant factor. This fear of judgement and breach of confidentiality when imagining being seen by an HCP from the same country was also raised by Fatima. Fatima

strongly objected ('*no, no*') to the idea of being asked by a HCPs from the same country as she feared HCPs would have the same permissive attitude towards DVA ('*same mind*'), judging her for disclosing and leading to breach confidentiality by informing her husband.

> *INT: Do you think it would be good if a doctor, nurse would be from the same country?*
>
> *RES: No, no, because you know, see, in the same country, I can tell you something, that I don't know how other country how they're thinking, but the same country who will be saying I need help from you, you can't say this because even with doctor from the same country, you know, he might be call for my husband and tell him, you know like this, but it would be better if like to have the doctor, English or a health visitor or staff like this, but with interpreter. You know for you, because you can explain, these people will help you, sometimes in our country, this man, this doctor man, or this woman, has abused already in his house, the same mind.*
>
> *Fatima, from Libya*

Again, the importance of gender is highlighted by Fatima because she mainly refers to a male doctor ('*he might call for my husband*'). Fatima also hypothesised that a male doctor from the same country could be a perpetrator in his home, while a female doctor may have experienced DVA herself. Thus, she prefers talking to an English healthcare professional with an interpreter as, in this case, she expects help after disclosure and not judgement and breach of confidentiality.

Maria was the only woman who, hypothetically speaking, had she not been able to communicate in English with her GP, would have preferred a healthcare professional from the same country (or fluent in her language) rather than using an interpreter. Maria felt this would ease communication and understanding and would facilitate disclosure of DVA. She only wanted her doctor to know about her private experiences and did not want to share them with a 'stranger' (i.e. an interpreter).

> *RES: The best thing is have the doctor the same country as you are or speaking very good your language is the best thing, yeah because you can understand and explain very good, er but otherwise, yes to use interpreter but interpreter you know it is like another one person, sometimes [...] she don't want somebody else to know, just her doctor so sometimes interpreters it is not really very good.*
>
> *INT: Erm. So it is another stranger in the room?*
>
> *RES: Yeah, yeah it is another stranger in the room yeah, yeah. yeah, yeah. Yeah.*
>
> *Maria, from Ukraine*

Disclosing DVA to a healthcare professional may be difficult enough and this may be amplified by using an unknown interpreter. This may also indicate a lack of trust and fear of breach of confidentiality when using interpreters. Notably, this aversion to using an interpreter was specific to DVA, as Maria maintained that using an interpreter would be appropriate for other not so sensitive health matters. The above quotes may suggest that the discomfort of having to use an interpreter to disclose DVA is only overcome by the fear

of breach of confidentiality and judgement some migrant women anticipate when using an HCP from the same country. Conversely, women who are not concerned with breach of confidentiality or judgement by the HCP may prefer using HCPs from the same country for disclosure.

Professionals, including those who had migrated or whose parents had migrated to the UK, gave discrepant accounts regarding the need for professionals to be from the same country (cultural congruence). One Sudanese HCP claimed that healthcare, including DVA services, would only be accessible for migrant women if the employed staff were from these migrant communities. Similarly, other professionals emphasised the need for being from the same country or having cultural knowledge, awareness or sensitivity. Without this understanding, they felt it would be hard to recognise migrant women's DVA experiences, for instance, regarding so-called honour-based crimes and respond appropriately. An IDVA exemplified this by referring to Banaz Mahmod, a young woman affected by honour-based violence, who was murdered by multiple relatives despite contacting the police and the hospital. This failure was due to not recognising this woman's danger, isolation and the multitude of perpetrators.

> *[…] her case didn't fit in the typical domestic abuse criteria, so she wasn't helped I don't think. The Police also there were failures in helping her as well as the hospital she went.*
>
> *Nina, working in the hospital sector*

It was also assumed that employing a professional from Somalia, although helpful for women from Somalia, might not be helpful for all Black and Ethnic minority (BME) women – because of not being aware of these women's complexities, cultures and languages. Consequently, helpfulness was linked to coming from the same country or culture and speaking the same language.

> *They've employed, for example, a Somalia woman to do some of their BME work but then she's just working with people from all different BME communities and that doesn't, that will help with the Somalia women and that's absolutely brilliant and I think that's a really good thing but there's almost, it feels that there's an assumption that she'll be able to help any BME woman and they come from all different complex backgrounds […] I'm not saying it's impossible for somebody of a different race to help somebody but it's more difficult isn't it?*
>
> *Frances Long, HCP, England*

This cultural congruence assumption also extends to British healthcare professionals, who feel unable to deal with abused migrant women and, therefore, need reassurance and training from migrant women to be made aware of DVA as a problem in their communities that should be asked about.

[…] she says there is domestic violence, it is quite common, people are really reluctant to talk about it, it's fine to ask about it, no one's going to be offended, you know it's quite a common issue and this is what can help, and this is what might stop people … You know.

While a DVA managerial professional noted that employing a Pakistani worker had almost tripled the number of Asian women accessing the DVA services overnight, she also stressed that finding the right, trustworthy person was crucial due to fears, for instance, of breach of confidentiality. One DVA professional with a Pakistani background noted that some Asian migrant women were desperate and happy to speak to someone in their language once they had reached DVA organisations.[66] At the same time, she and various other DVA and healthcare professionals also noted that some migrant women still preferred British professionals due to fear of breach of confidentiality. However, an alternative explanation could be that Asian women may prefer Asian workers but are not assertive enough and do not want to offend. Thus, there was no overall agreement within the sample regarding culturally congruent HCPs.

5.3.1.3 Summary of pathways to help/healthcare

In summary, migrant women only disclosed during a time of crisis, often to trusted individuals, with some directly disclosing to police, healthcare or DVA organisations. The role of HCPs in DVA disclosure was perceived as central; trust was also a pre-requisite here. Whether cultural congruence between HCPs and women is important for disclosure remains uncertain, as cultural congruence is shown to carry both benefits and risks.

5.3.2 Adequate healthcare responses

For disclosure to be helpful, it needs to be followed up by an adequate response. Some of these responses are very similar to the conditions in pathways to help/healthcare and thus will only be briefly outlined.

Four migrant women reported a positive response to disclosure of DVA in healthcare. This was due to a number of factors including: being listened to; feeling validated and not judged; receiving an appropriate non-verbal and verbal response; emotional support; ensuring women's safety by documenting the violence and asking them about whether they were in safety (from the perpetrator); if not already referred to DVA agencies, providing information about DVA services, legal aid and directly referring women to DVA services; and providing the opportunity to use an interpreter when the woman did not speak English. These elements were also raised by professionals who additionally stressed factors such as: the value of addressing women's feelings of guilt (i.e. that the DVA experienced was not

[66] DVA organisations may or may not be perceived as a safe(r) place to disclose.

their fault); providing choices; and progressing at the women's pace. Many of these elements are evident in Maria's description of her interaction with her female GP.

> *I told her what happened to me, I seen her face, she started so seriously, before she has been smiling to me always, very nice person and she start like her face changed so much, she start writing everything, she put everything on the computer about what I was saying. She asked me how I feel now, have I got the pain anywhere? I don't remember really all this part. I remember her face yes, yes. She asked me what the address, how my son feels, is my husband trying to contact me? What else? I don't know really what else. It wasn't long conversation, it was about five minutes, maybe ten maximum minutes. But she straightaway give me the phone numbers for this helpline. […] But how she really was listening and talking to me it has been making me calm down and in the finish I have stopped crying more concentrate what about what I am talking.!*
>
> *Maria, from Ukraine*

This quote highlights that although the consultation was not long, the GP's response – asking her questions, listening, showing concern and recording the violence – had a reassuring and tranquilising effect on Maria, who felt cared for and less alone. She also felt that she was speaking to the right person; this contrasted with her earlier perception that DVA was '*family business*' (see 5.2.3 'silenced by lack of knowledge and stigma: can't speak') and shows a change in Maria's attitude towards DVA.

Like Maria, Lina felt listened to when telephoning 111:

> *I felt like inside of me, um, it was a stone before and after speaking with that lady it was like that stone going into little stones. Um, she was brilliant. I think she was the first person who helped me to realise what I was going through.*
>
> *Lina, from Romania*

This quote shows that through being listened to, Lina felt validated, emotionally supported and was able to realise that she was affected by DVA. This conversation made the violence more manageable and less overwhelming. Following this conversation, Lina disclosed the violence in her children's schools. Thus, the HCP's response to her disclosure seemed to have an 'activating' effect, in that it led Lina to address DVA. While Lina assumes that the HCP was trained, it is not known whether this professional and Maria's GP had received DVA-specific training.

Marta went to see her HV in the community centre where she had learned English. This place was chosen as it was perceived to be safe. Her HV had also arranged an IDVA and a telephone interpreter, as Marta did not want to continue using an acquaintance. Marta feared breach of confidentiality and was, therefore, happy and felt safer when her HV booked a telephone interpreter for her. This language provision was essential for Marta to communicate (find her voice) and to find out about and discuss her options.

As some of the above quotes indicate, there was a great need for '*providing hope*: *there's a way out*' to migrant women – that a life without violence was possible and that there was help available. This was emphasised by both women and professionals. The provision of hope requires a combination of emotional support and information, which address the fears of consequences of disclosure:

> *I think they need a lot of reassurance that they are not on their own, that they won't be left alone to deal with all that.*
>
> *Stefania, HCP, from Poland*

As indicated earlier, HCPs' advice was sometimes directive. Two women were strongly advised to leave their abusive husbands (e.g. '*this man will kill you, you have to leave him, go away, take your child and leave him and go.')* Here, HCPs may assume a high risk of danger to the women and their children and respond accordingly. However, as can be seen in the quote below, the nurse also, perhaps only rhetorically, concedes that Nana could return. This indicates that rather than presenting women with choices, HCPs may feel that they must safeguard the women and their children and, therefore, advise leaving the perpetrators. Here, Nana's fears of being deported were also addressed.

> *[…] when I started, I was scared because I not have papers, until the nurse told me, 'no, you don't need to be scared, the only thing is you have to stop crying and then be strong'.*
>
> *INT: She told you that?*
>
> *RES: Yeah. 'Domestic violence they are not going to arrest you, they are not immigration officers and they are happy to get your documents'. 'So, stop crying. Yeah and then be strong, fight for your life and your little girl's life. Tell them everything from the beginning to the end, tell them. Don't be scared and don't think this man will get you again. That's his last stop, he will never see you again to treat you like this, unless you … you're free to go back, and I don't think you'll go back', and I said 'no, I don't even want to see him, I hate him'. [laughs] I hate him.*
>
> *Nana, from Ivory Coast*

Following Nana's disclosure, the next steps of telephoning the DVA services were made transparent '*I told the GP everything and he said I have to report you, give you to the domestic violence [services]*'. The HVs' desire to safeguard women was perhaps indirectly confirmed by DVA professionals, who noted that HVs often expected them to 'rescue' women from the perpetrators, regardless of what the women themselves want. This could cause conflicts between HVs and DV professionals

> *Now … the health visitors tend to think, my understanding is, that if there's any kind of abuse going on, refer the woman to (name of DVA organisation), even if she doesn't want any support, even if she wants to stay with the partners, so they see us as a kind of (name of DVA organisation) to rescue people, whereas what we are very strict about is that we do not do anything against the woman's will, she's an adult, it has to be her own decision what she is doing, we can give her options.*
>
> *Barbara, DVA sector, from Poland*

As evident above, DVA professionals are trained to provide abused women with choices to empower them to make their own decisions. Interestingly, while emphasising choices, Barbara also maintained that by stressing the effect of DVA on children (girls becoming victims and boys becoming perpetrators), migrant women would often be motivated to do something about the DVA. This indicates that there may be circumstances where migrant women appreciate more directive advice or immediate safeguarding rather than just being given information and choices.

This reflects a wider debate about choice and professional-patient decision-making, which will be addressed in my discussion. Given the language barriers, which make phoning a helpline extremely difficult, coercive control and financial abuse (which often denies or restricts telephone use), migrant women may need direct referral to access these services. This was also reflected by an HCP:

> *I mentioned a couple of times about (DV organisation), that's been variable sometimes as to whether the women will actually go is the biggest thing [...] it's whether they'll actually make the phone call, or whether they've got any credit on their phone to you know ... [...] but perhaps for migrant women they need a bit more support than that.*
>
> *HCP, England*

By only providing information about services, this may deny or delay access. The quandary between providing choices, maintaining confidentiality and ensuring safety/safeguarding was raised by various professionals. Some professionals felt frustrated and worried when women chose to stay with the perpetrator or returned, even when they recognised that leaving might be harder for migrant women due to intersecting repercussions, such being ostracised and being disowned by their own children.

> *[...] she's about 50 and we know that her husband has been violent towards her for years on and off and she just won't, you know she knows we know and there's nothing we can do. We always try and if we push it too hard, she just won't, she doesn't come back for a while.*
>
> *Frances Long, HCP, England*

Given these repercussions, staying may be perceived as the lesser evil – yet, it may require a special kind of support. The HCP and her colleagues struggled to '*tread that line*' between following up on DVA and not '*alienating*' the woman. Professionals recognised the need to maintain medical confidentiality when women chose to stay in abusive relationships but feared that these women may be killed. This HCP (below) worried whether she and her colleagues were doing the right thing by not intervening, as they felt that breach of confidentiality would tear the woman's world apart.

> *I don't know if we were doing the right ... Is it possible to know if we're doing the right thing because there's cases you hear about, isn't there, when someone suddenly gets killed but she won't if we did, her whole world would fall apart as well? So, I don't know the*

right, it's really, really difficult. [...] there's the dilemma of well when do you breach, the big one is when would you breach somebody's confidentiality, you know when do you feel like it's such a big issue that you would breach their medical confidentiality without their consent erm, and there's, so I suppose that would depend on how severe it was and who else was being involved, you know if women are asking you to not say anything then when would you, erm tell people anyway?

Frances Long, HCP, England

The dilemma of when to breach confidentiality could not be resolved in the interviews, as HCPs feared the consequences for women. If the police were notified of DVA, this may have become known to other authorities, such as immigration control and – depending on the action taken – to the women's husbands, family-in-law and social network. Due to the wide ramifications of breaching confidentiality, the HCPs concluded that any sharing of information outside the consultation required shared decision-making and transparency wherever possible.

Gender congruence or preference was not directly investigated in my interviews. Some quotes indicate that there may have been a preference for female HCPs or that female gender was implicitly assumed when talking about HCPs. Some professionals, such as HVs, are primarily female and these were considered very helpful by some participants, which may be an indirect confirmation for gender or being a HV, or both. However, Lina felt rushed by both her female and male GPs and was not asked about DVA by her HV. This indicates that time constraints are a general phenomenon which may occur with any HCP of either gender.

In articulating this theme, I have explored appropriate healthcare responses to disclosure. Despite all migrant women having had contact with healthcare, only for five women healthcare played a role in disclosure and/or obtaining help after disclosure. In three cases, although women accessed healthcare, it did not play any role in women's disclosure. However, its value for and after disclosure and separation was noted (e.g. to detect DVA). In my final overarching theme, I will discuss migrant women's needs after separation.

5.3.3 Holistic support needs

Migrant women faced many consequences after separation from the abuser(s). As already touched upon, this led – for example – to being ostracised, insecure immigration status and lack of or inappropriate housing. Non-English-speaking migrant women had to learn English to communicate and connect with others:

One year ago, I couldn't have this conversation, but I think you understand what I say.

Marta from Brazil

English language skills were also essential to seek employment. Some professionals reported a dearth of basic independent survival skills in migrant women, such as not knowing how to travel by bus, which influenced their health, wellbeing and needs. Healthcare was sought in some instances, such as for the consequences of housing issues and separation. These will be described in the following.

5.3.3.1 Mental health needs

Mental health was often impaired by the DVA, social isolation and/or being ostracised. This, in turn, could lead to healthcare use:

> *She went to a hostel and now she's living on her own and she's so unhappy and she comes back to me all the time saying that she feels that it's the electricity and the electricity is poisoning her and she … It only started after this horrific, it was totally horrific domestic violence and she left and she escaped and she's moved into this new flat on her own where she's quite isolated because it's away from all the people that she knew because obviously she had to move to a new area, but she won't have it that it's to do with what happened, she feels it's the electricity that's poisoning her and she's, erm, and so sometimes people don't get better straightaway, like sometimes I think oh well once you leave you know everything will be fine, but it doesn't, doesn't always work that way does it, so.*
>
> *Frances Long, HCP, England*

This woman experienced social isolation after leaving her abusive partner, which exacerbated the traumatic DVA experience but which the woman appeared to be in denial about. Instead, the woman attributed her symptoms to being poisoned by electricity. Making this link between DVA and her mental health required continued emotional support and engagement from her HCP, as well as appropriate peer support, which this woman was lacking. This quote highlights the enduring aftermath of DVA, which may be exacerbated by extreme isolation and lack of social support, aggravating migrant women's health. As a result, these women may seek primary care if no other source of support exists. This quote also illustrates the challenges of encouraging women to leave their perpetrators, and the consequences women face doing that.

Addressing these intertwined health and social needs of migrant women is challenging in healthcare due to time constraints, resources and types of available interventions. For instance, providing counselling or Cognitive Behavioural Therapy (CBT) was not seen to be appropriate here, as this would not address the woman's isolation and lack of community. Instead, connecting the woman with others and establishing a new social network was assumed to be more helpful than talking about the abuse.

> *Some people say well you know if 'just have some counselling if she would just let it all out she would immediately be purged and feel better' or 'if she had a bit of CBT', and I don't think that would work for her either, I think probably what's going to help for her is finding ways of getting more engaged with the community and to … You know she's sitting at home on her own all day, worrying about how ill she feels but if she can get a bit more*

engaged and get a bit more support and a bit more community, because I think that's more likely to help her than talking to somebody about what's happened. Whereas for some people talking about what's happened is helpful so…

Frances Long, HCP, England

The effect on identity and loss of belonging was earlier described by Aisha: '*you became British, you became white*'. This requires adequate support, yet that which the migrant women received was mixed: Mariam felt isolated, not understood in her DVA experience and generally unsupported in a DVA refuge. This triggered a panic attack, due to which Mariam had to spend a night in Accident and Emergency (A&E) services. There, Mariam received emotional support and attention, time, explanation and information about her panic attack and available healthcare services.

I spent one night there in the emergency, but it was really supportive because I think I had a nurse, she'd been around me for three hours and she passed me a lot of information. Another girl came and talked to me and she explained to me what a panic attack is because I had it, this is the second time and they just passed me to a different service, they offered me their support. They said to me, 'this is the number, you can call it.' I mean yes, it was very supportive from that healthcare provider, they, they were very supportive.

Mariam, from Sudan

The positive experience of care, support, information and attention over a prolonged time in the emergency setting was beneficial. Yet, the above quote may also again indicate a lack of knowledge about raising this type of distress in primary care. This also again highlights the need for adequate psychological support over time to stabilise migrant women and their need for information about mental health.

While DVA professionals recognised women's mental health issues and the need to be listened to, yet they lacked both time due to their main jobs (e.g. dealing with the Home Office or arranging housing) and mental health training. Professionals commented that they were not HCPs or counsellors:

[…] because we are not counsellors […]so [we] need to be really mindful of their mental health as well, and that we don't dig too deeply down because we don't want to realise [release] anything that we can't contain.

Lexi, DVA support worker, England

Although one professional mentioned mental health and advocacy training, this intervention was only available for English-speaking women; non-English speaking women were excluded. DVA professionals commented on the scarcity of counselling within their organisations, where the waiting time was six months. This way, migrant women's mental health needs often remained unaddressed. Barbara voiced a strong need for immediate interventions for women, whereby they would be able to talk about the violence and come

to terms with it. Rather than being trapped by the violence and its consequent distress, talking about it would make it more manageable by being able to step aside and look at it:

> *So more immediate intervention more, more abilities to basically listen to the woman because you know they, we are not going to change their lives, it's only them who can change their lives, once they throw it out from inside it's kind of out, so maybe then they can look at it, so like standing aside, you know, not when it's here, they can look at it objectively. So maybe that's easier to like help them diagnose themselves, diagnose their own problems, and maybe think of some kind of an action plan but it's very difficult to deal with things when we cannot actually see them, you haven't heard them they only like kind of stumbling around here (laughs).*
>
> *Barbara, DVA agency, from Poland*

Barbara also observed that several Polish women had experienced physical and sexual childhood abuse, which also needed to be dealt with. The scarcity of mental health expertise within DVA organisations suggests that they should provide better links with psychological services to support these women. To address this, and to make mental healthcare more accessible for Somali or Polish women, community groups were established. These groups were thought to simultaneously address the migrant women's mental health and social needs. The rationale behind this was to address the stigma attached to mental health and DVA and to enable women to access these groups without raising any suspicion from the perpetrator(s). To facilitate this, the groups were located within healthcare organisations and included a range of recreational activities, such as sewing.

> *[…] lots of the Somalia women we're seeing have had problems with domestic violence or depression or you know previous traumas and things but a lot of them present with a physical problem. So I worked with the (name of centre) which is attached to our practice and ask Somalia women, we've set up a Somalia women's mental health support group, but we don't call it that because nobody would go, it's called a (name) with sewing or something like that. […] But it's not fraudulent because it is, but that's the way to kind of try and draw people in.*
>
> *HCP*

Within these groups, DVA was also addressed by organising talks from DVA organisations and counsellors, among other events. Thus, these groups functioned as a door-opener for migrant women to access DVA agencies*: 'well someone of them phoned me and said what is (name of DVA organisation), 'what do they do, can you give me their number?'*. Yet, DVA was still very much concealed and not openly discussed in the Somali group ('*this happened to my cousin/friend*'). This may indicate that migrant women still fear a breach of confidentiality. It also suggests that these groups, on their own, may be insufficient as some women may need more one-to-one counselling – as proposed by one group facilitator. To provide equal healthcare access, it was considered that counselling had to be made more accessible by creating, for instance, drop-in counselling sessions at GP practices, and increasing migrant women's familiarity with counselling to reduce the stigma around mental health.

> *Therapist need to come out of big chairs if they want to help people [...] but how you can access it is another question. So, make it easier, you know make it easier to get in touch with you. Or I don't know, maybe make like a drop-in session (at the GP)*
>
> *Aisha, from Somalia*

Some professionals and migrant women criticised the notion of equal healthcare access. This was based on the idea that people knew about healthcare services and could access them. Yet, migrant women needed more information and communication about these services. Additionally, they may require specific support, such as practical and legal, if faced with deportation. Language barriers limit access to counselling, even when interpreting is provided.

> *When I said to her [...],'I think you need some counselling or something you know, this is just like driving you crazy', she said, 'but I couldn't use an interpreter at counselling because it just wouldn't be the same', so it must be a barrier you know having the [...] language barrier it's. It's more difficult isn't it, it's gonna be.*
>
> *Emily, DVA professional, England*

Thus, counselling in the woman's native language and cultural congruence may be needed. However, this poses an additional barrier to counselling, since access to English-speaking counselling is already limited. Not many migrant women had received counselling as a result. One woman contacted her GP and then received and appreciated her six counselling sessions.

> *Yeah, I ... I finished that, yeah and really it worked, it helped me a lot because I think the lady that she supported me, she's really an expert because the first session when I went I was like, 'Ah, shall I write down what I'm going to do, what I'm going to say.' The second session, the third session, the fourth session, it was like just normal conversation, but every time I go back home I just try to memorise what she said to me. To be honest, I worked hard to ... because as I said to you, I was scared at the first session, but the second session it was easy for me and I said okay, this woman she knows what she's doing so let me just follow her advice bit by bit and I haven't had that pen and paper in the session, I had it at home so I could write down. (laughs).*

The above woman's desire to plan the counselling sessions and record them afterwards may indicate her eagerness and intention to make the most out of these limited sessions, but also her unfamiliarity with counselling. It is unclear whether the counselling addressed this woman's DVA experiences and isolation, or only helped her to deal with the stress caused by DVA (e.g. suggesting reading to enable sleep). Considering her previous distress, including suicidal thoughts, six sessions seem insufficient. This shows that migrant women affected by DVA may need more sessions to help them come to terms with the violence, as well as its aftermath and the impact on their identities. This will be discussed in more depth in my discussion chapter.

Only one DVA professional recounted that, following severe sexual abuse, a migrant woman had received 12 counselling sessions, conducted via an interpreter. This migrant

woman had *described the counselling as 'really, really useful'*, but no more insights could be provided as to how the counselling was conducted using an interpreter and regarding its setting (within healthcare or in a DVA organisation). Various professionals maintained that if migrant women agreed to communicating via interpreters, they often chose someone who could speak the same language but was from a different country. Using the same interpreter was often found helpful. This enabled establishment of trust and rapport between the women and the interpreter, and the professional. The interpreter became familiar with the woman's story and this enabled a deeper engagement with the woman's concerns and issues rather than having to start anew each time. Although not explicitly mentioned, this means that the female professionals also become familiar with the interpreters, which helps with the consultation and provides some continuity of care.

Attending Freedom Groups[67] was often suggested to migrant women. Nana stated, *'I liked that Freedom programme more, and I stopped the counselling'*. Some interviewed professionals were trained in providing Freedom groups and partly facilitated these groups. There were mixed opinions regarding the value of such groups. Stefania was critical of the groups' focus on diverse aspects of past or current abuse, which she thought had a destabilising and possibly retraumatising effect. Instead, Stefania sought a programme which would give migrant women the resources, skills and knowledge to deal with the abuse and improve their overall wellbeing and health:

> *[…] the programme should rather concentrate on the future than on the past or present (in case if the violence is still happening). The reason being suffering, self-blame, depression, anxiety etc, which we shouldn't want to increase/deepen. We, the people who help, should concentrate on the ways of gaining (re-gaining) self-esteem, self-confidence, reduce level of stress, depression, anxiety. Our aim should be to help our clients become happy and live their lives to their full potential, not going through the worst moments of their lives again and again. Instead […] women should rather be given an opportunity to find out what makes them special, valuable, partners in a relationship, good mothers and wives. They should be given tools to manage their current situation, to be safe, to keep their children safe.*
>
> *Stefania, HCP, from Poland (email after interview)*

This risk of re-traumatisation was indirectly confirmed by Lina, who said that she and other women learned to identify other aspects of abuse they were subjected to (which they were previously unaware of):

> *At the Freedom programme where I'm going, there's a health visitor and she's ever so good. She's into the programme and she's, um, doing her best to find out more and she's doing her best to let you, um bring things out of you, which you haven't been aware of by now.*

[67] The Freedom Programme (Living with the Dominator) (http://www.freedomprogramme.co.uk/) is a free rolling programme aimed at women with DVA experiences, which lasts around 11-12 weeks. It was developed by Pat Craven, a probation officer, based on her experiences dealing with perpetrators and recording their abusive techniques. This group 'is provided by hundreds of agencies across the UK'.

Lina, from Romania

There may also be a risk that facilitators, who are not all medically trained, may indirectly contribute to blaming the women for choosing someone violent:

> *Like women's behaviour in type of men that they choose to be with, erm, and that is quite hard to deal with sometimes, erm, because women feel like they are victims when actually trying to empower them they are not victims, they have a choice, they have a decision to make and it is about recognising that [...]*
>
> *Lexi, DVA professional, England*

This choice Lexi refers to may, however, be limited for migrant women whose marriages were forced. Meeting and supporting other women with DVA experiences may carry the risk of re-traumatisation: while having little or no support themselves and not having sufficiently dealt with their own DVA experiences, Nana, Lina and Aisha supported other migrant women subjected to severe DVA. They found it hard to help these women and often felt helpless and frustrated, particularly when these women stayed with the abuser.

> *I have a friend, she's Romanian as well, she's suffering from domestic abuse and I think she's even been raped by him ... She's going through it now and she's still in the same house with him. She is saying, 'Oh my god, you're completely crazy, these people will throw you out in a second, don't you see what the government says about Romanians? Don't you see that?' She's afraid even to say, I don't know, I don't have, um, British citizenship, she has one, she has British citizenship as well, but she still doesn't dare to go out for help ...*
>
> *Lina, from Romania*

The above quote, again, highlights the fear of deportation and that by reporting DVA the perceived hostility by the British government towards Romanians would be ignited or confirmed.

5.3.3.2 Addressing children and pepetrators

While some migrant women did not realise, downplayed or denied the effect of DVA on themselves, they did want HCPs to address the impact of DVA on their children. Fatima and Maria found it very useful that their HV and support workers in the refuge helped them to re-establish or change their relationships with their children, which had been undermined by their husbands. Here, children had copied abusive behaviours, such as being verbally abusive and undermining. Fatima's relationship with her children had also been affected by Fatima's lack of English proficiency, which her husband had used to support his claims that she did not know anything – which her child believed and reiterated.

> *When I just came here my daughter she told me, 'Mum you need to go to a proper school because you don't know anything', who said that? 'My dad say that, because you don't understand anything, if I ask about anything I'll go and ask my dad not you, because you don't know anything'. Just now, like two months, three months I'm with help from the*

health visitor and the job, and make thinking about other ways of Mummy, Mummy is not just for cleaning and looking after you.

Fatima, from Libya

Fatima's daughter also functioned as teacher to help Fatima with her English, which also shows reversed family hierarchies, whereby children become more powerful and act as interpreters due to their language skills:

I know I can't speak English but, in the beginning, even I can't talk, and be, and my daughter, she's been teaching me.

Fatima, from Libya

Addressing these changed family dynamics requires external help, including helping migrant women learn English to be able to connect and communicate.

Somali migrant women acknowledged that DVA was a problem in their community and voiced a desire for DVA awareness campaigns and interventions that also addressed men:

We had the intelligence from the women in Somalia that domestic violence is an issue [...] they said we need to have workshops to raise awareness about domestic violence and what practical support is there. Also, they said to me, we need you to talk to men because it's two parts, it's two issues and they said that dynamic, the approach from the Somali community is we need to work with our men.

Ahmad, HCP from Sudan

This quote may be interpreted as Somali women wanting a solution that would address DVA and help prevent it, without having to separate from their husbands. However, men's knowledge and understanding of DVA may need to be addressed before their behaviour can be changed. This may require interventions specifically targeted at migrant men to tackle assumptions about DVA and the problems related to migration (e.g. unemployment, discrimination), which may cause or exacerbate DVA.

5.3.3.3 Healthcare advocacy

Several women needed healthcare advocacy for their ill health and issues with medication, as well as for general support with NHS consultations and examinations. For instance, due to language barriers, Marta felt misunderstood in healthcare settings. When HCPs worked within DVA settings, this facilitated better understanding and healthcare access for women: Marta's HV visited her regularly in the refuge and helped her to negotiate healthcare (e.g. by writing a letter to explain on Marta's behalf or helping her to change her GP).

I wasn't very well, my health visitor wrote a letter because she understood more. She wrote a letter for the GP and when I went to the GP alone, she knew everything because my health visitor had written a letter.

Marta, from Brazil

Following such support, Marta appreciated that when she booked an appointment with her GP the language line was also automatically booked. The HV also addressed wider needs, such as helping to get food for Marta.

Professionals from the DVA sector also acted as healthcare advocates by encouraging women to question why they were prescribed certain medication, to raise their mental health issues, discuss treatment for depression and seek counselling. However, some migrant women may also need an explanation about health check-ups, particularly gynaecological examinations, which they may have never experienced previously. Prior sexual abuse and not being familiar with gynaecological examinations could have made this examination even more 'intrusive'.

> *[…] so, she had a lot of swabs done and just a health check-up really but to her that was really quite intrusive coming from (area in South Asia) where that didn't happen. So, she found that really quite difficult, extremely difficult in fact. Erm, […], she was told that she was going to be checked over and to make sure her sexual health was fine, and she was, you know to… And they talked her through it but actually they didn't explain why they were doing it, why they had to do it, erm, to her it was just very intrusive. Erm, I mean that's her story, so I don't know, obviously didn't go to the appointments with her. But they had an interpreter with her but that's just how she found it very intrusive because she had never experienced that sort of medical before I suppose.*
>
> *Lexi, DVA organisation, England*

However, it should be noted, that every care had been taken to carry out this examination in a small and sensitive clinic run by only female staff. Here, the woman was also accompanied by a female interpreter. Yet, the exact way the examination was carried out was unclear; presumably, the interpreter remained behind the curtain. It also remains unclear as to how these medical examinations and issues can be explained in a way that makes this examination less intrusive – if that is at all possible.

5.3.3.4 Housing needs

Three migrant women had asked their HCPs to write supporting letters to the council to find appropriate accommodation. After separation, the housing situation of some women in refuges and hostels was very basic and often crowded ('*I'm stuck here, you know. I look after my kids; I live in one room'*). Due to living in hostels with so many children, Maria felt that her child was often ill due to being constantly exposed to other children. One IDVA described some accommodations in hostels as '*horrendous*'. This may force migrant women to return to the abuser(s).

Conversely, Lina felt unsafe in the house she had previously occupied with her abusive husband, who had tried to gain access after separation. This exacerbated her emotional distress and anxiety, which would not cease:

> *I'm so scared to stay in this house and I am … (Pause) There's no safety unless I'm out of here there's no safety. It doesn't matter how many locks they put on my door, there is no safety for my own health, not necessarily that he would come again.*
>
> *Lina, from Romania*

Consequently, this shows that healthcare is used for wider social needs, which are closely intertwined with DVA and impact women's health. Thus, migrant women's needs after disclosure and separation from the perpetrator were not fully 'medical', although they impacted women's health (e.g. being ostracised, social isolation). These issues often affected women's mental health, which requires accessible groups, counselling and therapies, not only for women but also for their children and husbands. Some migrant women also needed healthcare advocacy. Likewise, HCPs required more training about DVA and sources of help to assist abused migrant women.

5.3.4 Summary of 'finding a voice'

'*Finding a voice'* consisted of different pathways to support or healthcare, which were often triggered by crisis and depended on conditions such as trust. However, this trust did not seem to depend on the HCP's cultural congruence– instead, cultural congruence appeared to increase the fear of breach of confidentiality for some women. Adequate healthcare responses were related to listening, providing information and referrals and, thus, '*hope and a way out*'. However, migrant women experienced many healthcare-related issues after separation, such as mental distress.

5.4 Chapter summary

In this chapter, I have presented the healthcare experiences, pathways and needs of a heterogenous sample of migrant women with diverse forms of DVA. New perspectives on migrant women's healthcare experiences were gained by including abused women, who also provided their professional insights, and professionals, who shed light on unsafe interpreting and barriers to providing help. In particular, the need for cultural congruence was explored.

In my final chapter, I will combine my main interview and qualitative synthesis findings together and discuss them in the context of the wider literature.

Chapter 6: **Discussion**

6.1 Introduction

This chapter's aim is to summarise my synthesis and interview findings, compare them with each other and then discuss them in the context of the wider literature. The research reported in my thesis sought to examine the healthcare experiences, pathways and needs of migrant women affected by DVA using a systematic qualitative review and interview study as described in my previous chapters.

In the following chapter, I will compare my findings on migrant and with non-migrant women regarding their DVA and healthcare experiences, pathways to help and unmet needs. However, I must emphasise that neither non-migrant nor migrant women are a homogeneous group, so there can be some overlap between them.

I will start discussing migrant women's DVA experience, following which I will focus on migrant women's healthcare experiences. As with my overarching constructs and themes, I will structure this along a timeline: 1) healthcare access barriers, 2) inadewuate healthcare responses, 3) conditions for disclosure and patheways to support, 4) person-centred care experienced, and nedded, and 5) unmet (healthcare) needs. I will also discuss my conceptual model of migrant women's healthcare experiences using existing theory. Finally, I will describe my study's strengths, limitations and implications for future research, practice and policy.

6.1.1 DVA experiences, trajectories and perpetrators

In contrast to non-migrant women, migrant women's DVA experiences often differed regarding their onsets, forms (e.g. threats of deportation, enslavement) and perpetrators (e.g. family-in-law). My findings also indicate that many migrant women encountered severe, often overlapping, physical, sexual, psychological, emotional, financial DVA and coercive control (e.g. (209)).

For a substantial number of women, DVA started after migration simultaneously with their relationship or was exacerbated by it.[68] This indicates a difference in relationship initiation and DVA trajectory when compared with non-migrant women in Western countries.[69] Here, DVA usually starts gradually after an initially 'romantic' relationship with a single intimate partner. (191, 268, 269) Migrant women also experienced violence in the context

[68] In case of forced marriage, the consumption of marriage represented a violation.
[69] However, this may be similar to ethnic minority or women in their respective countries of origin.

of pregnancy ((209, 214, 218, 220, 223, 224, 226) interviews) and this has also been found for non-migrant women. (e.g.(224, 270)) However, reproductive coercion and forced terminations may be more pronounced for some migrant women and perpetrators of DVA were often husbands and the hubands' families. (209, 214, 216, 218, 220, 226) interviews) Previous research shows that living arrangements within the extended family and the cultural expectations of servitude and motherhood may increase the likelihood of DVA by the husband and/or the husband's family. (46, 47, 54, 151, 271, 272)

My findings are consistent with Crenshaw's (81) intersectionality framework: DVA intersects with migration and can make migrant women more vulnerable to DVA due to multiple dependencies (e.g. immigration status), language barriers and lack of resources. (e.g. (47, 271)) Erez and colleagues interviewed 137 migrant women from 35 countries in the US and conclude that men '*have access to unique forms of domination and control [over migrant women], some of which are facilitated or even sanctioned by federal immigration law*'. ((273), p. 51)

These women also encountered other forms of violence, including forced marriage ((209, 214, 216, 218) interviews), political conflict ((208, 226), interviews), discrimination and racism (204, 206, 209-211, 214), interviews) and living in violent or poor neighbourhoods. ((206) interviews) Thus, some migrant women may be victimised due to their gender, nationality, immigration status and lack of language.

> *Not only do different patterns of domestic violence have different consequences for different families, [but] intersectionality [also] asks us to integrate into theory and practice the simple recognition that, for many families, domestic violence is not the only or primary violence shaping family life ((274) p. 33)*

Previous research has found that discrimination and racism impact the health of migrant women affected by DVA. (44) DVA and other (structural) violence and precarious living conditions and possibilities may affect migrant women's health cumulatively and at the same time restrict healthcare access.

6.2 Healthcare experiences

In the following section, I will discuss my findings on healthcare access, inadequate healthcare responses, which were exacerbated by language barriers, person-centred care, pathways to support, unmet (healthcare) needs and the constrained help-seeking model derived in my synthesis.

6.2.1 Healthcare access barriers

Many intersecting political and cultural barriers constrained healthcare interactions.

Socio-political barriers included lack of immigration (204, 206, 210, 211, 214, 216, 219, 221) and/or insurance status (215, 221), knowledge about DVA, laws, support services, resources and language and language provision. Fear of consequences, such as deportation and loss of children, were great barriers. While barriers such as lack of insurance also affect ethnic minority (275, 276) and non-migrant women (277), other barriers, particularly a combination of these, such as immigration status, knowledge and language barriers are more specific to migrant women and represent general structural barriers to healthcare. (47, 54, 81, 162, 276) Thus, migrant women's experiences of DVA and healthcare were shaped by intersecting factors related to their gender, ethnicity, immigration status, language proficiency, socioeconomic status and class. (92) The greater the number of these often-intersecting barriers faced by migrant women, the more constrained the healthcare access and interactions. ((92, 209, 217), interviews) Previous research also found that the lack of immigration status and access to public funds alongside ostracisation may trap migrant women in abusive relationships, who may be forced to wait until they qualify for help by the government. (135)

Cultural values were attributed to emotional responses, such as shame and self-blame, staying silent and self-sacrifice – this significantly impeded help-seeking and disclosure. (e.g. (214, 216)) Similar barriers have also been identified for non-migrant women (e.g. (144, 231), yet these are seldom attributed to culture. When comparing Latina and American women affected by DVA, Kelly (209) concluded that Latinas were much more concerned with HCPs involving authorities than internal barriers, such as shame, embarrassment, ambiguity, denial and the reactions of family and friends. (p. 140) While the stigma of divorce and loss of reputation has been identified across all migrant (204, 208, 211, 212, 216, 218, 222, 223) and non-migrant women (143, 209), for diverse migrant women these social repercussions may extend to the whole family (e.g. (204, 208, 214, 216), interviews), resulting in loss of respect by the community (216) and ostracisation of women and children. (e.g. (208), interviews) While this may also apply to some ethnic minority women (e.g.(90)), there are additional legal, financial, and logistic consequences associated. (e.g. (208, 209, 214, 216, 227), interviews)

Coercive control, including threats about consequences of disclosure, by single or multiple perpetrator(s), severely controlled or denied healthcare access for women (209, 214, 220) – even for injuries. (e.g. (46, 214) Due to this some studies identified by my systematic literature search could not be included in my analysis, as women lacked healthcare experiences and interactions with healthcare professionals (e.g. (278)). This highlights a gap in research and the lack of provision of healthcare for these women, as they have not yet had contact with services and were 'hard to reach'. The healthcare encounter of non-

migrant women (228) is also inhibited by coercive control, yet for many migrant women this was additionally exacerbated by immigration status and language barriers. (209, 214, 220)

6.2.2 Inadequate healthcare responses exacerbated by language barriers

The healthcare interaction was constrained and inadequate as migrant women felt discriminated against, the healthcare professionals focussed on symptoms, which seemed exacerbated by language barriers and lack of adequate language provision. There were also inappropriate responses to suspicion or disclosure of DVA.

Women also experienced discrimination due to lack of language skills (204, 209-211, 221), racial prejudice (204, 211) and lack of insurance or payment status (215, 221), as partly found in my interviews. However, it could not always be discerned whether discrimination by HCPs was intended or unintended. As discussed earlier, racial or ethnic discrimination is a major barrier to seeking and receiving help for ethnic minority women and in healthcare encounters. (90) A US study by Johnson and colleagues (279) analysed 458 audiotaped healthcare consultations and found that that physicians were more verbally dominant and less engaged and patient-centred with African American when compared with white patients. Both African Americans and the HCPs showed overall less emotional affect. (279) This may support migrant women's perception of discrimination in the healthcare encounter.

Due to lack of language provision, husbands were used as interpreters in both studies in the synthesis (207, 228) and my interviews. This severely undermined communication about DVA, for which reason there are many recommendations not to use husbands as interpreters. (231, 258, 280, 281) Moreover, the interviews revealed that HCPs may find it difficult to deal with husbands who act as interpreters. (228) Wider research, nevertheless, found that husbands, family members or friends were used as interpreters – with the latter finding out about DVA not because of choice, but because of lack of options. (282)

Adequate translation is needed, as the use of a lay person may lead to mistakes, omitting information, not translating exactly what was being said and instead providing the interpreter's own version (283). According to Bent-Goodley, ((284) p.91) it '*is not just the words that [can] get lost in the translation but also the context for the words and meaning behind the language*'. Being called a '*victim of domestic violence*' can be perceived as offensive. (284). Communicating via a professional interpreter can also be problematic due to migrant women's fear of breach of confidentiality, the interpreter's male sex and a lack of sensitivity. This was also found in my interviews and synthesis.

These barriers have also been identified in general non-DVA research. Patients from former Yugoslavia in Sweden saw interpreters as a barrier. (285) The availability/shortage of adequate interpreters can also significantly increase the waiting time for a consultation. (285) Moreover, the use of interpreters does not inevitably lead to successful communication (283) – this is dependent on the interpreter's characteristics, such as sex, age, attitude, appearance and sensitivity. (285) The barriers created by use of interpreters are particularly high if the topic is sensitive (285) My synthesis and interviews also indicated this, furthermore, it was found that interpreting must be provided in a safe and confidential setting to ensure the safety of migrant women, the interpreter and the professionals.

My synthesis and interviews revealed that *diverse* healthcare professionals frequently focussed on the women's symptoms (202, 205, 206, 209, 214, 221, 222) without investigating the cause and prescribed medication, including antidepressants and/or tranquilisers. (206, 209, 214, 221) This has also been found for non-migrant women. (231) However, language barriers and lack of adequate interpreters seemed to further exacerbate this focus on symptoms and poor communication (e.g. (202-205, 209), interviews): some migrant women did not receive or understand their diagnoses or the prescribed medication. (206, 214) Written information was often only available in English. Lack of knowledge about the diagnosis, medication (e.g. particularly antidepressants) and their side effects, as well as the stigma of mental health problems, exacerbated women's anxiety (e.g. (214) interviews), leading them to not take or discontinue their medication. (214)

Antidepressants were also prescribed to non-migrant women for symptoms of DVA. (143) Here, women's satisfaction depended on whether their use was appropriate for the women's situations and whether any additional help was offered, such as counselling or practical advice. (143, 144) This is congruent with my synthesis and interview findings. One US study on Hispanic migrant women found that these women wanted to know what was wrong and to get better. (221) These women were grateful when they were explained that their physical symptoms were caused by depression and violence (221); this echoed my interview findings, where migrant women also sought comprehensive information about depression with the aim to destigmatise it.

This mirrors the findings of a meta-ethnography on antidepressant medication, which found that its use was linked to patients' decision-making. Decision-making was closely related to patients' experiences with medication, including side effects, improved health, beliefs about illness, concerns of addictions, the relationship with their HCPs and the perceived impact of taking antidepressants on self-identity. (161) The study suggested

exploring the patients' scope for shared decision-making by considering and being sensitive towards patients' shifting preferences and experiences. This included finding out whether patients feel stigmatised for having to take antidepressants and addressing it.(161)

However, when communication is impeded, patient care is compromised. (203) This may severely interfere with an empathetic connection with the HCP, which on its own may be therapeutic. (286) It also decreases diagnostic power, impairs patient education, concordance and follow-up, often resulting in patient dissatisfaction. (204, 206, 214)) Impaired communication may result in patient autonomy being violated by HCPs providing paternalistic care. (286) Communication about and understanding of medication is also crucial from an ethical perspective to enable shared decision-making and informed consent. (283) Prescribing medication without any or only partial explanation excludes migrant women from making an informed decision. (214)

Previous research indicates stigma and a lack of knowledge around mental health issues and services among migrant and ethnic minority women, which causes these women to seek less mental care compared to non-migrant women (287, 288)– despite encountering more severe and more frequent violence. (8, 44) Diagnoses such as depression can also impose an additional stigma onto migrant women (137), as they already feel stigmatised because of their ethnicity and DVA experiences. Diagnoses can also confirm perpetrators' claims that there is something 'internally' wrong with the women – that *they are* crazy. (137) This can increase women's feelings of self-blame (137) and can also lead to loss of child custody (209) and deportation. (289)

My synthesis and interviews identified other inappropriate and potentially harmful responses to suspicion or disclosure of DVA. (202, 205, 208, 209, 212, 214, 216, 218, 224) These included rushed screening, silence, pressuring women to disclose (209), blaming women, telling them to leave the perpetrators or return to their countries of origin. Breach of confidentiality was also reported, whereby husbands were remonstrated (216), the police was phoned against women's will (208) or leaflets were sent by post to one woman. (224) These responses often left women feeling undermined, ignored, discouraged and '*often exacerbated the women's sense of disconnection and isolation that was the direct result of the abuse and their immigration experiences*.' ((209) p. 143).

Negative responses to disclosure, such as judgement, have also been reported by non-migrant women. (143, 144). However, these negative responses seem to be more pronounced for migrant women (208, 216, 224); this is considered unsafe, as research shows that women are at increased risk for homicide when perpetrators suspect that they may leave (e.g.(268)). This may also indicate misconceptions about 'culturally' appropriate

responses to DVA identified in wider research (to be discussed next). Research on disclosure has generally stressed the importance of the confidant's reaction in predicting whether disclosure will be perceived as beneficial or not. (290)

6.2.3 Pathways to support/ and disclosure

The trigger for disclosure was most often a crisis related to the severity and impact of DVA on women and their children, as also identified by previous research. (e.g. (291)) Healthcare was sought both directly and indirectly and facilitated by receiving information from trusted individuals, including healthcare and other professionals. Healthcare professional elicited trust by providing person-centred care, as also found in previous research on non-migrant women. (143) Help was also often found outside healthcare via the police, DVA organisations and the wider social network. (135)

Both my synthesis and interviews identified a delay in help-seeking and disclosure of DVA. (209, 212, 216, 217) Previous research suggests that the level of acculturation may affect identification and disclosure of DVA. (96, 97, 105-107) However, the intersectional barriers (e.g. lack of immigration status) constrain help-seeking and disclosure. While this delay has also been found for non-migrant women (e.g. (135)), it appears to be more pronounced for migrant women (e.g. (222)) due to the additional constraints.

6.2.4 Person-centred and culturally competent care?

The synthesis and interviews also discovered some helpful encounters in healthcare, where women described a positive and caring relationship with professionals. Here, HCPs were perceived as caring when they showed interest in migrant women as people (202, 204, 207, 209, 210), listened attentively to them, displayed congruent non-verbal behaviour and provided continued care. (202, 204, 206, 207, 209) This was necessary to establish trust, which was a prerequisite to sensitively enquiring about DVA. This was appreciated by women if it was followed by non-judgmental listening, validation, emotional support, information, referral and continued care, while also ensuring safety and autonomy. I termed this 'person-centred care' as it corresponds to the definition put forward by Stewart (2001):

> *Patients want patient centred care which* (a) *explores the patients' main reason for the visit, concerns, and need for information;* (b) *seeks an integrated understanding of the patients' world—that is, their whole person, emotional needs, and life issues;* (c) *finds common ground on what the problem is and mutually agrees on management;* (d) *enhances prevention and health promotion; and* (e) *enhances the continuing relationship between the patient and the doctor.*
>
> *((292) p. 445)*

My synthesis and interview findings are congruent with a meta-analysis of DV survivors, which highlighted the same factors (143) and other literature. (144, 149, 292) When absent, person-centred care was shown to be desired by both migrant and non-migrant women (143) – indicating that it appears universally appreciated and confirming previous healthcare-related research. (292) The value of 'social interaction' and person-centred care may be particularly important for migrant women in creating trust and rapport and counteracting fears – as said before, HCPs may represent women's only and longest outside contact due to coercive control and lack of social contacts. (e.g. (209))

As language and/or cultural barriers constrained help-seeking and help-receiving (209), some authors suggested including linguistically and/or culturally congruent HCPs (202-204, 206, 208, 209, 216, 221) or training in cultural competence. (202) Vietnamese migrant women, for instance, reported lay health personnel from Vietnam as helpful due to being able to speak in their language and feeling understood. (208) However, for some Hispanic women, it was more important that HCPs could speak Spanish; professionals did not necessarily have to be Hispanic. (206, 209, 221) Some Hispanic women were even willing to put up with compassionate non-proficient Spanish speaking HCPs with whom they felt *'a sense of connection'*. ((209), p. 107) This again seems to support the importance of person-centred care.

In my synthesis, Rodriguez (202) found subtle cultural differences between Asian and Latina migrant women in how they wanted their HCPs to respond to them, although both groups sought a compassionate and supportive context. There may be individual and intra-cultural variation influenced by factors such as acculturation: Kelly found that lowly acculturated Latin women expected a caring approach from their healthcare professionals, while highly acculturated women only expected '*straight medical care.*' (209) However, both the women and professionals I had interviewed provided similar accounts of how trust developed and this was dependent on time, listening skills and interest – as captured in the above definition.

Some authors argued that a certain form of understanding may be needed, although it remains unclear what exactly it relates to. It may represent a general non-DV-specific person-centred care approach (e.g. by being understanding, showing care, empathy and kindness), a specific understanding of DVA (202) or having a cultural understanding of the political and cultural pressures on abused migrant women (208, 214) or all these elements. This may indicate the need for cultural competence, which, however, considerably overlaps with person-centred care at the personal level. (293)

There may be differences between primary healthcare and mental healthcare. Asian and Latina migrant women wanted to speak to a bilingual therapist to avoid the use of interpreters in mental healthcare. Thus, the healthcare setting and sector (e.g. DVA agencies) may determine whether migrant women prefer talking to someone in their native language (and from the same country or at least culturally competent). Previous research by Thiara (140, 294) has found that migrant women felt much more comfortable and positive about DVA services when they could talk to women who came from the same culture or country and spoke their language.

While some migrant women experienced HCPs from the same country (e.g. India, Saudi Arabia and Vietnam) in a positive light (208, 216, 218, 223), my synthesis and interviews also showed that some women were afraid of breach of confidentiality and judgement when using a healthcare professional from the same country. Due to these fears, diverse interviewed African migrant women preferred talking to non-migrant professionals or professionals from other countries, with the help of interpreters (if required). My synthesis also revealed a double disadvantage for some South Asian migrant women in Canada and the UK, whereby they feared judgement and breach of confidentiality from Asian healthcare providers but also did not feel understood by mainstream non-migrant HCPs. (214, 216)

This corroborates literature showing that some UK Asian migrant and ethnic minority women did not seek healthcare for fear of breach of confidentiality when staff, including receptionists, were from the same country or culture. (295) Another UK study found that in some UK cities, South Asian women were automatically allocated to South Asian doctors and as it was argued that these professionals would understand Asian women better; however, as shown in my findings this could instead serve to the women's disadvantage. (296) A US study (297) found that the adequacy of Korean doctors' responses to DVA in Korean women depended on the doctor's acculturation: the more acculturated doctors took a less permissive stance towards DVA compared to the less acculturated doctors, who often agreed with the perpetrators. (297) Thus, being from the same country or culture does not necessarily make HCPs better at responding to DV *per se*. (296)

HCPs' underlying cultural assumptions may also serve as a barrier. Informing families was misunderstood to be a culturally appropriate way of 'helping' South Asian (migrant) women by some British doctors. (296) Involving the family may perhaps be misunderstood as a culturally appropriate response, yet this is highly inappropriate and dangerous when women are affected by DVA. Conversely, a lack of 'presumed' cultural competence caused British and American doctors to not intervene when suspecting DVA, as they feared offending women or appearing racist. (275, 296) This was also echoed by an interviewed

HCP, who proposed that DVA training by migrant women would help emphasise to HCPs that DVA is a problem in their communities and that asking these women about it would not offend them. Some non-migrant professionals also thought that professionals could help migrant women best if they came from the same country or culture. However, as said before, my research indicates that some Asian and African migrant women may prefer non-migrant professionals.

Cultural competence, or cultural sensitivity, may improve healthcare responses to migrant women affected by DVA. (298) Rodriguez and Saba (298) postulate that culturally competent care requires HCPs '*to become comfortable with differences; acquire the ability to control and change false beliefs and assumptions; respect and appreciate the values and beliefs of those who are different: think flexibly; and behave flexibly*' to avoid stereotyping by only memorising culture-specific values and behaviour. ((298) p. 184) This requires a life-long commitment to self-reflection and humility. (299) The authors suggested using the LEARN model to improve cross-cultural communication. (e.g. (300)) This includes listening to the patients' perspectives, explaining their own perspectives, acknowledging differences, recommending treatment plans and negotiating a mutually satisfactory solution. As said before, there appears to be significant overlap between cultural competence (or sensitivity) and person-centred care at the personal level. (293) Yet, at the system level, for instance, a diverse cultural workforce and the effective use of interpreters may set it apart. (293) Awareness regarding one's own implicit biases is also important; thus, both need to be addressed to improve the response to migrant women affected by DVA.

Generic cultural trainings may have the opposite effect. In one study, doctors received contradictory messages, which '*simultaneously demanded 'understanding' while proclaiming that doctor-patient differences of background and culture simply precluded 'true' understanding and sensitivity';* this increased their *'cultural distance'* and made them unsure and fearful of how to respond to abused migrant women. ((296), p. 425) Here cultural 'otherness' may be emphasised, while overlooking the shared experiences and needs for sensitive and responsive healthcare perhaps desired by all abused women and this presents an obstacle to providing equitable medical care. (296) A recent review on general cultural competency training of healthcare professionals shows that it is often not used in day-to-day care due to many constraints such as time. (301)

Knowledge and training about DV, the interplay of cultural factors and its barriers, may not be enough in changing attitudes (and implicit biases) and providing compassionate and person-centred care. Knowledge alone may not translate into empathy, which may

represent a more innate HCP quality or a mix of skill and attitude. Further studies are needed to examine whether generic or specific training in cultural competency address migrant women's needs and whether they make HCPs more confident in tackling stigmatised problems.

6.2.4.1 How should DV be raised?

While some women preferred for DV to be raised directly (202), others favoured indirect questions (207, 209). This synthesis shows that preferring direct questions may be related to the length and quality of their relationship (202) – that is, the longer the relationship with the HCP the more acceptable direct questioning. (228) Rushed screening was found to be counterproductive. (209) A previous meta-analysis also found the preference of women regarding questioning about DVA depended on the context and length of their relationships with their HCPs. (143)

The healthcare setting may also affect screening, disclosure and satisfaction with healthcare responses. In my synthesis, women in one study reported more proactive DV screening and greater satisfaction with the responses of their health visitors or midwives when compared to their GPs. (214) The reason behind this could be that women may have felt a greater degree of intimacy with their midwife (209). Some interviewed migrant women and professionals also indicated a preference for HVs. In contrast, Feder and colleagues' (143) study did not find any preference for the type of HCP asking about DV.

The key feature of screening is the requirement to ask all women about DVA within a specific healthcare setting. The screening experiences reported by women were negative, screening was often rushed, and the Norwegian study found that midwives were perceived as powerless after disclosure. (228) This indicates that adequate responses must be in place for screening to be helpful. Previous research (302), the NICE DVA guidelines (281) and WHO IPV guidelines (258) concluded that evidence for the effectiveness of screening was insufficient and instead promoted low threshold asking about DVA. Whatever the method of identification of DVA (which should not be rushed), professionals should be equipped to give a response that is appropriate and safe. (280)

Women in both the synthesis and interviews desired more information about DVA before and after disclosure, including its mental and physical health impact on them and their children and the relevant health and DVA services and laws. Kelly (209) proposed that HCPs provide pre-emptive information about the outcomes of disclosure '*prior to any disclosure to alleviate migrant women's fears and uncertainty about the conseques of disclosure.*' Interviewed women also suggested that there was an emotionally supportive

aspect to this information, as it was crucial in providing hope of a way out. Both women in the synthesis (209) and interviews stated that information, particularly about the impact on children, would have motivated them to leave earlier. (228)

6.2.4.2 Gender congruence

There was no unanimity as to whether migrant women preferred a female HCP. Some authors argued (207, 211, 214, 216) that gender congruence increased women's feelings of trust, confidence (207, 214) and safety. (214) However, some migrant women experienced negative healthcare responses from female HCPs and, conversely, positive responses from male HCPs (e.g. '*he listened to me like a brother*' (202) p. 310). Thus, rather than gender, enacting person-centred care may be more important for women experiencing DVA.

Gender congruence may depend on the healthcare setting; for instance, it may be more appropriate for a gynaecological examination (211) – although this was not the case for all migrant women (209, 211)– yet this preference for gender congruence, particularly in the context of gynaecological examinations may also apply to non-migrant women. My interviews only shed limited and indirect light on this: some migrant, particularly African, women may prefer female HCPs. A previous meta-analysis on all, not specifically migrant, women could not resolve gender congruence either. (143) The issue of whether migrant women prefer a female HCP may simply be resolved by asking the women. (211)

6.2.4.3 Autonomy versus safety needs

The synthesis and interviews identified both autonomy and safety needs. (e.g (202)) While some migrant women in the synthesis only wanted advice from HCPs to maintain their autonomy, other migrant women silently wished for the HCPs to involve the police on their behalf for their own safety. (202, 209) Others, on the other hand, did not want police involvement and even feared it. (e.g. (208, 209)) The fear that immigration authorities and the police would become involved was also echoed in my interviews, where it presented a significant obstacle for healthcare provision. This is a fine line to tread, as maintaining a woman's autonomy or agency may result in further violence.

Interviewed migrant women, such as Nana, may need to be put in touch directly with DVA services rather than just being signposted. There seems to be a considerable time delay between women receiving this information and them acting on it (e.g. going to a DVA shelter and self-support groups). (209, 212-214) This delay, also identified in previous research (135), may be caused by women not being able to access these services. (143) The IRIS intervention addresses this by training GPs to directly refer abused women who want this to DV services. (153, 258, 259)

Maintaining this balancing act requires a lot of support from colleagues or outside organisations. The HCPs' link to DVA agencies is crucial here, as stated in the NICE guidelines. (281) HCPs may also need to learn more about the role of DVA professionals in supporting affected women – that they cannot 'rescue' women. Given the consequences of separation, some migrant women may consider staying in the abusive marriages or relationships as the lesser evil. These women require support to minimise risk in their relationships. (222)

6.2.5 Migrant women's unmet needs

The synthesis and interviews identified various unmet needs of migrant women, including person-centred care (as discussed earlier) as well as their and their children's emotional needs.

My synthesis and interviews identified numerous needs related to separation and the intersecting DVA and migration experiences of migrant women, which often impacted their mental health. Some of these needs were legal, practical or social and were often interlinked; for instance, obtaining a secure immigration status, finding accommodation or work, lack of language, and social isolation. (81, 206, 221, 227) Healthcare was sought for these needs both indirectly or directly to, for instance, support their housing applications. Wider literature has also identified these broader needs. (e.g. (54, 129))

Migrant women wished for HCPs to address the emotional and behavioural impact of DVA on their children and help them improve their relationships with them. This has also been found for non-migrant women. (303) However, the inability to communicate in a shared language with healthcare providers was specific to migrant women. Here, family hierarchies and roles were undermined by the perpetrator/s due to the mother's lack of language. Thus, it is vital to improve a migrant mother's relationship with her children by also addressing her English-speaking proficiency.

Lack of social support and social isolation had a great impact on migrant women. A supportive social network has been found to buffer the effects of trauma in non-migrant women (304, 305) by providing emotional, practical, and financial help, such as housing. Migrant women often lack this social network. For instance, South Asian women in the UK were often deeply traumatised by both their DVA experiences and losing contact with their family when they separated (214). This shifted their '*whole sense of reference and self-identity*' which was '*connected to their belongingness within their community*'. This was also found in my interviews (e.g. '*divorce means becoming white*'). (214) By disclosing DVA they were perceived as having prioritised their own needs over their families', thereby contravening cultural traditions. This often induced feelings of shame. (101)

Previous research (306) found that if an arranged marriage fails, Asian women would not only feel betrayed by their husbands but also by their families, into whose hands they had put their trust. Together with fatalistic views, such as karma, women may feel that they deserved this because of wrong doings in their previous lives. (306) This translates into different emotional needs when compared to non-migrant women, who do not (normally) experience arranged marriages and ostracisation, or the impact of this on their identity and religious beliefs. Thiara (294) asserts that migrant women may '*require higher levels of support over a longer period*' since they often face *'extreme isolation and feelings of guilt due to thinking that they have failed both their families and their community*'. (p. 4)

The ability to establish a new social network seems linked to education, English skills, formal (e.g. counselling) and informal resources (e.g. family and friends) and faith. A recent study on Asian migrant women found that high resilience was connected to actively adapting one's social network after separation. (307) However, this study included mainly highly educated Asian women, who could speak English or were attending English classes – this ability to adapt may be reduced in women who are less educated and more marginalised. Adapting social networks may be enabled by community groups or other sources of support for migrant women.

Some migrant women did not recognise, or minimised, their own mental health needs (e.g. (213, 214), interviews). Most migrant women in the interviews and synthesis had not received or reported any counselling or therapy partly due to lack of access (costs and location) (206, 214), long waiting lists (206, 226), lack of childcare and/or language provision. (214) This indicates that migrant women's mental health needs remained largely unaddressed. Thus, some migrant women spoke to their key DVA workers about their emotional or mental health needs. While all workers were empathic and supportive, particularly when they worked in the refuge, many felt that they lacked time[70] and training/education ('*we are not counsellors/healthcare professionals*') to deal with this psychological impact of DVA. While a mental health intervention (PATH Psychological advocacy towards Healing) exists in the DVA setting to provide psychological advocacy (308), this intervention requires English language skills.

When migrant women accessed mental healthcare (206, 212-214, 219, 221, 222), satisfaction varied. This again depended on whether DVA was addressed and how care was provided. Some women reported a lack of person-centred care, which affected the relationship with the HCP (206) and lack of cultural and linguistic provision (206, 214),

[70] This especially applied when their job role required securing accommodation or helping with the immigration status.

due to which migration-specific issues (e.g. social isolation) were not addressed. (206) Satisfaction also depended on whether the care was continued or disrupted due to, for instance, staff turnover. (206, 211, 214) This once more highlights the need for and importance of continuity of care. Many migrant women wished for more (214) or more closely spaced (211) sessions (i.e. not every 14 days) with the same HCP. (211) One interviewed woman received six sessions of counselling for dealing with her (self-described) stress-induced panic attack, which was useful and improved her sleep. Yet, given the shame and stigma she felt due to her separation, the length of support was insufficient. This shortage of adequate and comprehensive mental healthcare has also been reported for the general population. (309) The waiting times are often long and the counselling sessions in the NHS are mostly limited to five or ten sessions (309), which are not necessarily trauma-informed.

Support groups were identified in both my synthesis (e.g. (212, 213, 219, 221)) and interviews in helping address the psychological needs of migrant women in terms of social support and information. (214) These groups could be facilitated by healthcare professionals, such as nurses, or specialist DVA services and could be embedded in healthcare or in the community. However, they may not be useful for migrant women who are concerned with breach of confidentiality. Consequently, some may prefer attending support groups in addition to one-to-one sessions ((212) interviews).

In my interviews, there were mixed opinions regarding the Freedom programme in the UK. This programme aims to educate women to recognise abusive behaviour and its impact. (310) While some migrant women appreciated meeting other women and learning about DVA, some professionals and one woman worried that explicitly discussing various forms of DVA may lead to re-traumatisation and destabilisation, which was echoed by one woman. Concerns about re-traumatisation, by being exposed to traumatic experiences, have also been raised in other non-migrant group interventions; for instance, mothers are often concerned that DVA group interventions aimed at children may be harmful by exposing children to the traumatic experiences of other children. (303) As the Freedom Programme focusses on self-chosen relationships, it may not capture migrant women's experiences of arranged or forced marriages, nor address migration-specific aspects and language needs[71]. More research is needed to evaluate its usefulness for migrant women.

This highlights the need for specialised DVA and healthcare services. Mainstream DVA services may not be orientated towards migrant women's actual needs (e.g. language, diet, securing immigration status) (81) but may instead pursue a broader idealistic goal to

[71] Yet specific Freedom groups exist for BME women, which may address this.

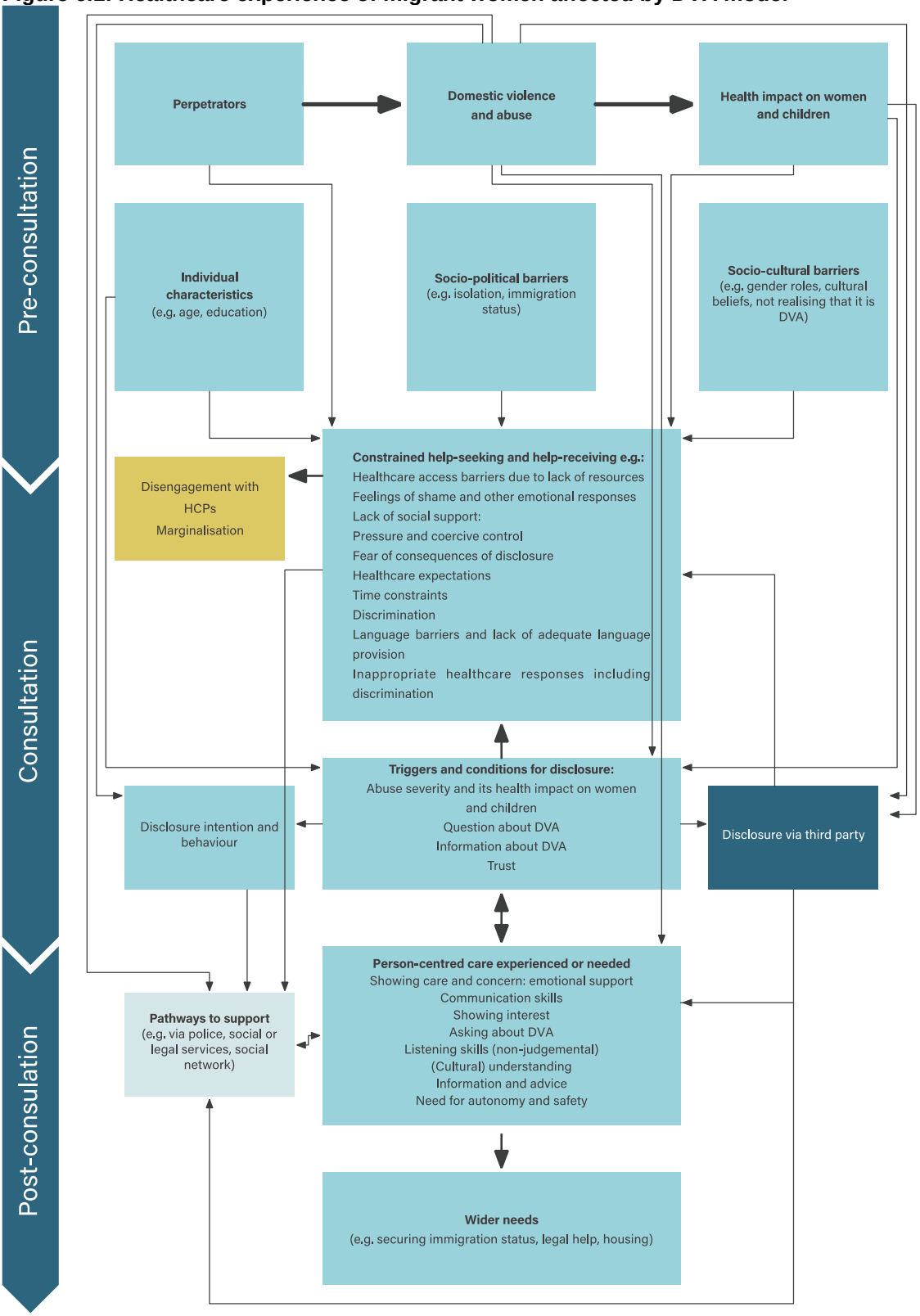
emancipate migrant women. (311) Stereotypical views of migrant and ethnic minority women have serious implications for the efficacy of the help provided. (311) HCPs addressing the mental health impact of DVA in migrant women need to know about intersecting factors relating to both DVA and migration (e.g. immigration status, ostracisation, no recourse to public funds).

Finally, the interviews found that migrant women also sought programmes for their husbands to address the violence (so that these women may not have to leave). However, there is a scarcity of such programmes. Whether the cultural context model (312) as suggested by Ahmad and colleagues (216), which uses so-called 'culture circles' and positive role models for men and women before and during therapy model (312), would be appropriate and safe for the women requires further research. Here, both victims and perpetrators are targeted by addressing the issue of intersectionality and dissecting gender roles, as well as the cultural and socio-political conditions underlying these. (312)

6.2.6 Help-seeking and help-receiving in healthcare model

My secondary and primary research identified a wide range of issues, such as healthcare barriers, help-seeking, healthcare use, communication and needs of migrant women affected by DVA. Migrant women must cope with both DVA and migration, and as described earlier, there is an overlap between DVA, migration and healthcare experience and needs. The conceptual model I derived in my line-of-argument synthesis captures healthcare barriers, help-seeking, conditions for disclosure, person-centred care and healthcare experiences (see Figure 6.1 below). I will relate these constrained healthcare interactions to theory.

Figure 6.1: Healthcare experience of migrant women affected by DVA model



Help-seeking models have been used to understand the help-seeking behaviour of women with DVA. (126) Ahmad and colleagues' study ((216), included in my synthesis) discussed their findings regarding help-seeking using Ajzen's theory of planned behaviour (TPB (313)) and the Behavioural Reasoning Theory by Westaby (2005). (314) Azjen's theory of

planned behaviour (TPB) (313) describes how (a) attitudes, (b) subjective norms and (c) perceived control regarding behaviour interact to form (d) intentions, which then determine the behaviour itself. The Behavioural Reasoning Theory by Westaby (2005) (314) assumes that '*reasons serve as important linkages between beliefs, global motives (e.g., attitudes, subjective norms, and perceived control), intentions, and behaviour*' and builds on the Theory of Reasoned Action and Theory of Planned Behaviour. (313, 315)

Theories of help-seeking emphasise women's cognitions involved in making the decision to seek help; i.e. (i) recognition that there is a problem and (ii) that this problem requires outside help. (126) However, not all migrant women were aware that they were experiencing DVA, nor did they realise its impact on their and their children's mental health. Some women were also unaware that they could raise this in healthcare, or they simply could not access healthcare. As migrant women's disclosure was often triggered by crisis, this disclosure seems to indicate an *ad hoc* rather than an 'informed decision'. However, disclosure could also be facilitated by trust derived from a person-centred interaction in healthcare.

While help-seeking may be attributed to the women (their individual factors), the intersection where these women are located is influenced by factors related to migration and socio-political conditions (e.g. lack of immigrations status, lack of access to funds). Help-seeking theories neglect the context of these wider barriers. (216) Intersectionality explains that many migrant women encounter additional, intersecting barriers when seeking and receiving help, based on their gender *and* nationality. However, it is not clear as to which elements (e.g. immigration status, lack of language, ethnicity, class) constrain healthcare access and interactions the most.

Help-seeking theories also do not capture the role of healthcare in this interaction, as most help-seeking models centre on the 'help-seeker's' behaviour rather than considering the 'helper's behaviour' (e.g. discrimination), too. The healthcare interaction may also be influenced by acculturation. As previously mentioned, this is mediated by the recency of arrival, the receptiveness of the host society (including the HCPs), the degree of similarity between culture/country of origin and the culture of immigration (e.g. regarding language, customs, healthcare), as well as demographic factors (e.g. age, gender, education, class and occupation). (112) HCPs may represent the only or longest-standing contact with the host society/country of residence. Thus, healthcare interactions (e.g. discrimination vs support) may not only impact migrant women's help-seeking behaviour, emotions and health, but may also influence women's acculturation.

Few women in my synthesis and interviews seemed to feel integrated; instead, many seemed marginalised, at least at some stage, both from their culture of origin and family and friends due to ostracization (*'Divorce means becoming white, becoming British'*), as well as from the host society, due to lack of language skills and discrimination (e.g. (206, 208, 209, 216, 218)). Interviewees partly attributed this to their appearance; for instance, wearing a headscarf, or having an accent.[72] This perhaps supports Berry's marginalisation category. Thus, some migrant women must come to terms with the health consequences of both DVA and migration, which may lead to, for instance, loss of social networks and discrimination. Some women in the studies of the synthesis and interviews reported suicidal ideation and/or suicide attempts (206, 214), which they attributed to DVA, lack of social support or understanding of their situation and the belief of there being no way out. Healthcare, therefore, plays an important role. One UK study found that South Asian women who were psychologically distressed and self-harmed only accessed services at the point of desperation rather than prior to any crisis. (295) The authors concluded that this indicated a need for services to respond rapidly when these women asked for help. (295)

6.3 Challenges, personal reflections, strength and limitations

In the following section, I will discuss the challenges I encountered while *doing* the research, alongside the study's strengths and limitations. I will also make some personal reflections.

6.3.1 Inclusion of different migrant women

In this thesis, I have examined the healthcare experiences, pathways and needs of *diverse* migrant women affected by DVA in current or previous heterosexual relationships, irrespective of their country of origin or immigration status. I did not select specific migrant groups and treated them analytically as one category, while remaining sensitive to intragroup and intergroup differences. Consequently, a possible limitation of my research may be ignoring differences between the migrant women from diverse countries (mainly Latina and Asian women, with some African and European women) included in my thesis in terms of healthcare access (including immigration status and healthcare provision). The inclusion of different migrant women was done to enable theorising across communities, which has been previously identified as a research gap (30); previous research has often concentrated on one migrant group (e.g. (208, 212)), although this could include, for example, diverse Latina or Asian women. (e.g. (214) Few studies have included a range of migrant women (e.g.(202-204, 222, 228)) and the current study sought to address this. While there are many intergroup and intragroup differences, I also identified many

[72] This has also been found for other migrant groups. For instance, Turkish migrants or descendants report discrimination both in Germany and in their native Turkey. This shows that they feel 'alien' in both countries.

intergroup and intragroup similarities regarding healthcare access barriers and healthcare interactions related to immigration and insurance status, language barriers, knowledge and 'cultural distance'.

6.3.2 Challenges

Searching for studies on migrant women in the systematic literature review was problematic, as there is no consensus regarding a *single* migrant definition (17). Migrant women were often masked under the umbrella terms '*ethnic minorities*', '*racial minorities*', or '*race*', which made it difficult, if not impossible, to discern whether these studies could be included.

My PROSPERO protocol inclusion criterion ((187), Appendix 1) instructed for inclusion of foreign-born women only – yet this did not reflect the complexity of migration trajectories. For instance, there were a few cases where women were, for instance, US-born, but migrated to Puerto Rico as a baby and then returned to the US aged 18 years. (206) I decided to include these women since they were raised in Puerto Rico and lacked English proficiency.

6.3.2.1 The balancing act: anonymising data versus data integrity

As experienced by anyone researching sensitive topics, anonymising migrant women with DVA experiences was challenging. To maintain migrant women's and professionals' anonymity, nationalities, age and other factors were presented in box table form. While DVA research – particularly that presented in theses – often provides brief contextual summaries of women's DVA experiences (e.g. (205, 224)), I decided against it here to prevent identification.

Instead, I provided neutral descriptions for places, DVA organisations and omitted names. The occupations of all women and professionals were changed or given an overall description (e.g. professionals in the healthcare sector became HCPs). The quotes only contained the pseudonyms, which were chosen by the participants and the women's or professionals' countries of origin. It is possible, however, that this may increase the risk of identification. Whenever two extracts increased the likelihood of identification, I used Saunders and colleagues' (316) smoke screen strategy - that is, I omitted the pseudonym. However, this can be criticised for compromising the integrity of the data and for misleading the reader. ((316) p. 621)

6.3.2.2 Communicating via an interpreter

Language was a constant issue throughout the research process, especially when conducting interviews, transcribing and analysing data – notably, because I am not a native English speaker. When using a female interpreter, my experience partly mirrored the use of interpreters in healthcare due to issues surrounding consent, coercion and professionalism.

When arriving to conduct an interview with an Indian woman via an interpreter and explaining the study, the Indian woman did not want to be recorded, presumably because she feared breach of confidentiality. I was not sure whether and how much the woman had been informed about the interview previously and considered leaving. However, both the woman and the interpreter eventually persuaded me to carry out the interview only by taking notes. Due to concerns about informed consent, I interviewed her only very superficially regarding her migration and healthcare experiences and have included only contextual information about the woman in my findings.

Using an interpreter affected the dynamics of the interview. Due to previous interpreting contacts with the woman, the interpreter was familiar with her and they discussed other issues during the interview. Although I interviewed the migrant woman, looked at her when asking questions, listened to her and the translated responses, the woman predominantly looked at the interpreter. This made me feel removed from the woman. The interview also took much longer. Thus, to me this interview process paralleled, to some extent, the use of interpreters in the healthcare setting: there was a fear of breach of confidentiality and a need for professional and neutral interpreting. Interpreting also changed the interview dynamics and prolonged the interview.

6.3.2.3 Lost in transcription: heard but not understood

All interview recordings were sent out to an agency for *verbatim* transcription. However, some participants had strong accents and/or limited English proficiency; here, transcripts took much longer in comparison to transcripts from British professionals. This has also been found in previous research: according to one study, the average time for transcribing non-native transcripts can be 12 times real-time than for spontaneous native speech. (317) The returned transcripts often contained a high number of unclears (up to 86), which I had to correct. Moreover, the content of the interview was partly altered: in some interviews the grammar was corrected, noticeably transforming migrant women's English and sometimes apparent meaning; in other transcripts, passages were completely misunderstood. This echoes previous research that there is a much higher level of disagreement between

transcribers here than when transcribing native speech. (317) This required time-consuming corrections, yet also allowed me to immerse myself in the data.

Consequently, these transcripts perhaps also mirror the healthcare encounter: interviewees were heard but not understood. Researchers aiming to conduct similar research in the future need to be aware of this and allocate enough funds and time for transcribing the interviews and checking the transcripts. Agencies specialised in transcribing non-native interviews may be a solution. However, while this may increase the quality and accuracy of the transcripts, it may also raise confidentiality issues. Another option would be checking these unclears, dilemmas and trade-offs with the interviewees.

I noticed a similar loss in translation effect when reading some publications on Latina women for my synthesis. Some of these included original quotes in Spanish translated into English. Here, (due to my Spanish knowledge) I felt that some of the emotional content may have been lost in translation.

6.3.2.4 Women's research motivation and reimbursement

As discussed in my interview methods, migrant women's motivation to participate was often altruistic in helping other abused migrant women. This is in line with previous research (e.g. (209)). As a token of appreciation for taking part in the research, interviewed women received High Street vouchers.

For some women, although not being the primary incentive for partaking, these vouchers were still important. These women often lived in refuges or hostels with no or only limited access to public funds. Some of these women had participated in various DVA research projects and, thus, perhaps used this experience as a way of supporting their children and themselves. This influences the data generated for DVA research.

The use of High Street vouchers was not appropriate for all women. One asylum-seeking woman commented that she did not want to go to the shops supported by the voucher scheme as she primarily wanted to buy food for her family. Fortunately, the voucher included one supermarket, although she considered it as normally '*too expensive*' for her. Thus, the use of vouchers over money may be an inadequate means of thanking participants, as it forces women to spend in predefined shops rather than in shops of their own choice, or to pay bills. The use of vouchers may also be perceived as derogatory and paternalistic (asylum seekers often do not receive cash to ensure that they will only spend it on prespecified items).

According to Judith McFarlane, a US DVA researcher, research money should go to where the knowledge is: to the women affected by DVA. For her research, she reimburses women considerably and in cash, thereby also achieving low attrition. While not agreeing entirely with her position and not wanting to promote incentive payments, reimbursing vulnerable participants may require further research, while adhering to ethical standards.

6.3.3 Personal reflexivity

Social science usually focusses on investigating and reporting of 'the other' – that is, participants' experiences, views and meanings. In contrast to positivist research, which promotes scientific research to be 'objective' and has no place for the social context of the researcher (*De nobis ipsis silemus* – of ourselves we are silent[73]), (318) qualitative research, questions this notion of objectivity and recognises that the researcher impacts the whole research process – starting with the research question, conducting of the research and the interpretation and co-construction of findings. (318) Consequently, the researcher's view cannot ever be completely removed from the research process (nor should it) and the insights generated can never completely be objective and value-free. (319) In recent decades, there has been a 'reflexive turn'; feminists and postmodernists also recommend a process of reflexivity. (320)

> *Reflexivity requires critical self-reflection of the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process. It demands acknowledgement of how researchers (co-construct) their research findings. Reflexivity both challenges treasured research traditions and is challenging to apply in practice.*
>
> *(p. ix, Finlay and Gough (320))*

This personal 'transparency' is, however, challenging. Intersectionality is a good concept to explain my own background in terms of socio-demographic information, historic positions and current locations and how these shaped my research: I am a white mixed European-Asian (my mother is German; my late father was from Jordan), non-native English-speaking woman from Germany. I am married to my Spanish husband and I have one son. My academic background lies in psychology and public health. During my Master's in public health, I first researched DVA among migrant women and then wanted to put theory into practice. In a women's counselling centre in Germany, I helped migrant women affected by DVA by devising and carrying out outreach campaigns in language classes and counselling these women. After that, I started my PhD.

Throughout my research, I have reflected on how my PhD topic relates to my own professional, migration and personal experiences. Apart from working with migrant

[73] This was coined by Francis Bacon in his Novum Organum first published in 1620. (318)

women affected by DVA, I, for instance, also helped a friend avoid a forced marriage. I have experienced racism and discrimination. For instance, when I was eight years-old, an elderly German lady on several occasions told me threateningly that I would not have existed under Hitler (due to having a Jordanian father).[74] As a migrant woman in the UK, I have also experienced discrimination. Unrelated to violence and migration (yet significant), I became pregnant during my PhD and gave birth to my son – which may have heightened my attention and sensitivity towards reproductive coercion and forced terminations.

These experiences shaped me as a person and how I think and feel about DVA and other forms of violence. This affects my lens, through which I read, conducted interviews and analysed my data. My experiences may have enabled me to understand DVA and migration at a deeper level and, I hope, made me more sensitive when carrying out the interviews. A shared migration experience seemed to have enabled an instant connection with many migrant participants. My Arabic surname led some participants to see me as an 'insider', for instance, by saying '*you know what Arabic men are like*'. This has also been found in previous research. (321) I tried to counteract this by asking the women to explain this to someone who did not know Arab men. Being a non-native English-speaking migrant woman may have put migrant participants at ease and lowered the power differential when being interviewed in English. However, in some instance, this may have conversely caused more distance with native interviewees, although I generally did not notice this.

By keeping a research diary, I sought to document how my experiences shaped how I conceived, conducted and analysed my data – thereby enabling me to make this more transparent. As said earlier, I also discussed my interviews, coding, analysis and synthesis with colleagues and my supervisors. I also attended supervision provided by a trained counsellor for our DVA research group, where I could talk about my research and issues related to this.

6.3.3.1 Reflections on timeline and analysis

My interviews were carried out in early 2013[75] before conducting my systematic review and synthesis of qualitative studies in autumn 2014. Thus, the findings of my qualitative synthesis did not inform my interviews. For this reason, I could not further explore discrepancies, for instance, regarding gender congruence. However, not having had these prior insights may make consistencies with my synthesis more compelling as I had fewer preconceptions. It should be noted that I was not *naïve* when conducting the interviews

[74] This happened while I was reading many books about the genocide against Jewish people and bemoaning these atrocities.
[75] From February until April 2013.

due to the above personal background and experience and knowing some of the wider literature, including studies that were included in my synthesis (e.g. (202, 207, 208)). This wider literature informed my topic guides and let me to identify some research gaps (e.g. regarding cultural congruence).

In 2017, I revisited and re-analysed the interviews. This temporal sequence may have influenced my analysis and findings. While my interview findings can be incorporated into the conceptual help-seeking and help-receiving model derived in my synthesis, they also shed important insights into the healthcare experiences and needs of migrant women (e.g. regarding cultural and linguistic congruence and the use of interpreters and pathways). These insights were enhanced by also interviewing professionals dealing with migrant women affected by DVA (e.g. regarding safe interpreting and ongoing (mental) health consequences of DVA and ostracisation). To my knowledge, this has not been investigated and my research, therefore, makes an original contribution.

6.3.4 Strengths

In this section, I will outline the strengths of my study.

While previous research on the healthcare experiences and needs of migrant women affected by DVA has been undertaken, it tended to focus on a small number of migrant groups in specific countries. No prior study has tried to synthesise these experiences across diverse migrant women in diverse countries. This study is, therefore, an original contribution that addresses a key gap in the literature.

A strength of my systematic review lies in the comprehensive search I conducted using three search concepts (DVA, migration and healthcare) in six different electronic databases to identify and locate relevant studies; grey literature was also systematically searched using three electronic search bases (for theses and grey literature).

My interviews were conducted in the UK. They support, add to, but also go beyond my review of literature from different national contexts by including a) diverse and previously unstudied nationalities and b) diverse professionals (e.g. interpreters) to produce new insights. Previous studies seldom included diverse migrant women (e.g. (202, 228)), instead they either centred mostly on a) specific or grouped migrant women (e.g. Mexican (217) or 'Latina' women (209), or b) were based on professionals (e.g. (322, 323)), but rarely investigated both groups. (e.g. (205, 215, 225, 296))[76]. My interviews make a unique contribution by providing in-depth, multifaceted and new insights relating to: (i) language barriers and language provision, including diverse perspectives, experiences and needs

[76] In one study, HCPs mainly described their experiences with non-migrant women.

regarding the use of interpreters (e.g. safety and confidentiality issues); (ii) cultural congruence; and (iii) person-centred care (including HCPs' dilemmas); (iv) pathways to help; and (v) unmet needs (e.g. mental healthcare needs, interventions for children). Including both groups in my interviews also made a triangulation of migrant women and professionals' views possible. While I pieced together and synthesised the healthcare experiences and needs of diverse studies and contexts, my interviews elicited most of these experiences and needs in one single study, yet they also went further. For instance, my interviews show that assumptions about cultural congruence appear more complex than previously reported. (214) 215, 299) While using culturally congruent HCPs has also been identified as a barrier for some South-Asian women in the UK (299) and Canada (216), this issue has not, to my knowledge, been explored with diverse migrant women and professionals. This presents a unique contribution. Like Puri (299), I identified partially discrepant assumptions regarding migrant women's presumed need for culturally congruent professionals. These assumptions may partly reflect professionals' feelings of cultural (in)adequacy (i.e. due to being (or not) being from the same culture). Thus, cultural congruence appears to be a double-edged sword. While some migrant women preferred communicating via an interpreter to using a culturally congruent HCP because of fear of being judged or lack of trust, others did not. While employing culturally congruent HCPs is an important aspect of culturally competent care at the system level (293)–in terms of DVA this may require these HCPs to genuinely, actively and prominently position themselves against DVA to counteract any fears of judgement and breach of confidentiality migrant women may have. This again highlights the need for trust, elicited by person-centred care (thus perhaps emphasising the *how* and not the *who* in providing care). Its components were identified by both migrant women and professionals and appear to equally apply to the personal and professional context and thus seem universal, rather than culturally bound. My findings may thus question previous cultural attributions (e.g. (215, (214), 147) of negative healthcare responses (e.g. judgemental responses such as 'just leave' or rushing) and needs (e.g. HCPs being non-judgemental and non-directive) as these have been identified for non-migrant women, too, without, however, attributing them culturally. My interviews also begin to address an important gap regarding migrant women's pathways to help, where crisis *and/or* trusted individuals who provided information (e.g. that disclosure would not lead to deportation) were crucial in accessing and disclosing in, for instance, healthcare. My interviews reveal that many migrant women still did not know that they could raise DVA in healthcare. Yet as healthcare was mostly accessible[77], it played a vital role in dealing with the often long-term unacknowledged and stigmatised mental

[77] While there is universal healthcare in the UK – particularly access for undocumented women affected by DVA, remains difficult.

health consequences of DVA and issues related to this (e.g. lack of adequate housing, social isolation). My findings show that training and close multi-interagency work between healthcare and social workers or IDVAs improved the healthcare response to DVA, which has also been identified, for instance, for undocumented Latina women in the US (e.g. (227), and women, including migrant women, in the UK. (e.g. (239)) However, my interviews also identified HCPs dilemmas when suspecting or providing help for affected migrant women (e.g. assumptions of cultural congruence, ostracisation, lack of access to funds). Community groups, which do not overtly address mental health and DVA, were identified as a door opener for accessing DVA agencies and counselling. Finally, I also made methodological reflections regarding my interviews (e.g. interviews with non-native speakers, transcription and reimbursement), and gave practical advice.

By combining these two different methods (systematic qualitative review and interviews), my research question was explored from different perspectives – described by Flick as a 'systematic triangulation of perspectives'. (324) Thus, the boundaries of each approach may have been, at least partly, overcome and the breadth of inquiry increased. (324)

6.3.5 Limitations

Here, I will discuss the limitations of my study related to language, the 'interview mode', sampling and the generalisability or transferability of my findings.

Apart from one interview, discussed above, seven interviews with migrant women were conducted in English. This could be seen as a limitation as I excluded migrant women who could not speak English. While the option of using an interpreter existed, none of the seven women requested this. Two of these women had only recently learned English. Women reflected repeatedly on their previous lack of English during the interview: '*but do you know, before, how do I say, before I couldn't, er, have a conversation'* (Marta from Brazil). Being able to conduct the interview in English was a great achievement for these women, of which they felt proud[78]: this literally meant that they had found their voices. It also demonstrates that meaningful interviews are possible with migrant women knowing little English.

However, using an interpreter may have been easier for the women and prevented ambiguities (easing transcription). Both women expressed themselves well, despite errors in grammar and the use of tenses. For instance, the women sometimes mixed up pronouns,

[78] Needing to learn English was a necessity in this refuge as they did not have any support workers who could speak their languages and to communicate to the other residents in the refuge. However, despite this lack of linguistic congruency, the women felt enormously supported and cared for by the staff.

saying '*him*' instead of '*her*'. Nevertheless, I felt at ease clarifying most of these ambiguities.[79]

I found it more difficult to understand some migrant professionals some of whom had lived and worked in the UK for a long time. I did not ask to conduct these interviews with an interpreter and felt less confident about clarifying points in these interviews, as I did not want to offend them. I hoped to better understand these interviews when reading the transcript or listening to the recording; however, the transcriber had similar issues and here the number of unclears was particularly high.

Some studies reported the benefits of conducting more than one interview with their participants (206, 209, 222), such as, establishing or enhancing trust and rapport between researcher and participants. (223) Repeat interviews can also enable member checking (184) – a technique whereby data or results are checked by participants to explore whether the results identified by the author resonate with the participants. (325) This technique is used to establish credibility in the 'truth' of findings. (184) Some study designs required a second or subsequent interview(s) (206, 222), for instance, to allow women to reflect on their own and other women's experiences and to promote emancipation. (206)

I only conducted one interview with each participant and did not perform any member checking. While it can empower participants by treating them as co-researchers, it may affect participants differently – either becoming an additional strain, be therapeutic (325) or be of no interest to them. (326) This also poses a time constraint for the researcher as it provides more data to analyse. Research participants may also lack the skills to assess the analysis, as this would require widening the scope to beyond their individual stories. While recognising the limitations of member checking, a second interview may have been beneficial for clarification purposes. (316) For instance, this could have included checking that participants agreed with my presentation of their stories and quotes, ascertaining the temporal order of events or resolving ambiguities related to language. In my interviews, I generally felt that women were willing to share their DVA and healthcare experiences.

6.3.5.1 Recruitment

Snowball sampling enabled access to both migrant women and professionals but inevitably resulted in sampling a group of individuals who delivered or were in contact with DVA services. Thus, the use of professionals as a gatekeeper to access women has limitations.

[79] However, some problems understanding the women arouse, as they recounted their stories inconsistently as there was some confusion about the temporal order of events, for instance, when they sought healthcare. This might have been general memory problems. Sometimes I forgot to probe, or perhaps thought I had understood and could listen to recording later.

Recruiting migrant women via DVA services is a limitation as this only reaches women who sought and received help via these organisations. Thus, this sample may not represent migrant women who do not access these services, due to coercive control or who choose to stay in abusive relationships as DVA may be perceived preferable to deportation or homelessness. More affluent migrant (like non-migrant) women may not use these DVA services as they may have other means to escape abuse. Finally, this research did not study same-sex relationships.

While I had hoped to use purposeful sampling, for the women and professionals, I was highly dependent on using DVA workers as gatekeepers. However, I was fortunate in that the interviewed migrant women naturally varied in terms of countries (although countries from the African continent dominated), ages (although not much variability), religion, educational backgrounds and occupations, socio-economic class, family status, children, languages spoken, English proficiency, immigration status and time of migration. They also had varied healthcare experiences. The professionals were also engaged individuals who may have similar opinions about how to improve healthcare access for migrant women affected by DVA. This may limit generalisability, as their insights may not reflect 'common practice'.

The sample of migrant women was small (n=8), which limits the transferability of the findings. Yet the information power of the sample (327) was sufficient to address the aims of the research, particularly when combined with the results from the synthesis review. Thus, it may not be possible to draw conclusions for the general migrant population in the UK or elsewhere. However, Malterud and colleagues (327) argue that small sample sizes may still hold enough information power, this depends on (1) the study's aim, (2) the sample specificity of the participants, (3) the use of established theory, (4) the quality of the dialogue and the (5) analysis strategy. (327) I had a broad aim (experiences, pathways and needs) and my research was informed by a few existing studies. I did not want to generate a theory but gain insight into migrant women's experiences in the UK. Consequently, I interviewed migrant women (and professionals) who had specific experiences, knowledge and properties. However, as my interviews were conducted in the UK, which provides universal healthcare, my findings more comparable to studies in other high-income OECD countries, which also provide this (e.g. Canada), and perhaps not so much to others which do not provide this or low-and middle OECD countries. This requires further research.

6.4 Recommendations for future research, medical curricula, practice and policy

This thesis conceptualises the healthcare experiences and needs of migrant women with histories of DVA. As such, this research has significant implications for future research, policy and practice, which I will describe in this section.

6.4.1 For future research

My findings reinforce the case for including all forms of DVA in the scope of research, policy and healthcare. If prevention and intervention efforts focus on 'intimate partner violence' by a single male perpetrator, the DVA experiences and perpetrators encountered by migrant women (e.g. by female family members) are overlooked and remain unaddressed in healthcare and beyond.

There needs to be a clearer definition regarding migrant women. Until now, migrant women are not easily discernible in studies, which has made this synthesis (and likely future ones) difficult.

Further research on migrant women affected by DVA, who do not access healthcare and other services, is needed. This could be done via English classes or community groups. However, careful thought should be given to the technicalities of carrying this out to not endanger these women and provide adequate aftercare. More studies are needed to examine the multiple types of violence faced by migrant women and its differential impact on their health and identity. Furthermore, the factors which keep migrant women affected by DVA healthy need to be longitudinally studied.

This synthesis found that person-centred care was perceived as helpful and desired by all migrant women. It was unclear, however, whether culturally and linguistically congruent care was desired by all migrant women, as there were confidentiality concerns and the potential for harmful responses. The above may depend on the setting (primary care vs counselling) and the language proficiency of individual migrant women. This requires further investigation.

Qualitative studies are needed to examine whether training cultural competence in DVA meet the experiences and needs of affected migrant women, particularly regarding empathy and confidentiality – whether this training makes HCPs more sensitive to the issues as assessed by migrant women and whether HCPs require more help to address their own biases, stereotypes, anxieties and communication skills.

6.4.2 For medical curricula/training of HCPs

There is still a lack of training for healthcare professionals regarding DVA, particularly among migrant women. Existing national and international guidelines address how to generally improve healthcare for women affected by DVA or healthcare for migrants (281, 328) but not both. All involved parties dealing with migrant women affected by DVA in healthcare, such as HCPs and interpreters, should receive training on DVA and related safety issues, including vicarious traumas. If needed, allied professionals such as interpreters should be debriefed after working with migrant women. HCPs and wider professionals' (e.g. interpreters) roles and needs regarding helping these women must also be identified and addressed in training.

The existing IRIS intervention which improves identification and referral of women affected by DVA (153) covers a few issues regarding DVA among migrant women. Yet, one interviewed professional perceived this information to be insufficient and unspecific. While the IRIS handbook covers factors affecting migrant women in more depth, it is unknown whether this is taught in the regular IRIS training and how much the handbook is used by clinicians.

A recent study made films about non-migrant and migrant women's DVA experiences for a patient information website (Healthtalk). [80] This website provides information on the health experiences of different population groups in written and audio/video form, based on qualitative research. It is unclear how much this has reached affected migrant women, as they may not be able to access these online resources due to coercive control, lack of knowledge and language barriers as the website is only available in English. Nevertheless, there is potential for the Healthtalk DVA module to be used as part of the IRIS training.

6.4.3 For practice

For my recommendations for practice, I built on previous work by Feder and colleagues (143) and present this in a temporal order, by stages of interaction with migrant women (see Table 6.1 below).

[80] '*Healthtalk.org provides free, reliable information about health issues, by sharing people's real-life-experiences*'.http://www.healthtalk.org/peoples-experiences/domestic-violence-abuse/womens-experiences-domestic-violence-and-abuse/topics

Table 6.1: Recommendations based on stage of consultation

Before disclosure or questioning	• Have a broad understanding of DVA, including additional forms of DVA and perpetrators (e.g. wider family, multiple perpetrators) and common barriers migrant women may face (fear of deportation, social isolation and lack of knowledge, lack of access to public funds) • Speak to the woman on her own, that is in a physically safe environment and develop suitable strategies for this enquiry; if this is not possible, arrange for a follow-up consultation • If a migrant woman does not speak any English, please arrange for an interpreter. o Ask the woman if she is fine with this and, if possible, whether she has any specific preferences (e.g. an interpreter who speaks the same language but is not from the same country) o The interpreter should be female and a professional, ideally with previous DVA training o The interpreting should be done in first person without 'editing' anything. The interpreter should refrain from any judgement o The interpreter should sign a confidentiality agreement, and this should be explained to the woman. If telephone interpreting is used, confidentiality should be explained to the woman too Please note: Using an interpreter will prolong the consultation; it will require establishing trust and rapport so that the three-way communication can work Look and communicate directly with the migrant woman and be aware of any signs of discomfort and address these • Try to ensure continuity of care, which may also need to be explained to the migrant woman as they may not know that this is possible. Continuity of care is crucial for establishing trust and rapport • Assure the migrant women about privacy, safety and confidentiality; yet also explain the need to breach confidentiality via an interpreter • Place leaflets and posters in the medical setting to raise awareness about DVA and that it is an appropriate topic in healthcare. This information needs to be available in various languages and in graphic form and should be tailored to the needs of migrant women (e.g. address the consequences of disclosure) • Make sure that the clinical environment is caring, welcoming and non-threatening • Explain the time-limited nature of consultations in the first consultation • Be attentive and use open and appropriate non-verbal behaviour (e.g. tone of voice), a migrant woman may perceive rushed behaviour as a sign of lack of care • Be compassionate, supportive and respectful toward the woman • Ask questions about mental health using non-psychological terms • Find out more about the migrant woman's country of origin, how she came, for instance, to the UK; whether she feels isolated
When the issue of DVA is raised	• When symptoms are present or suspecting DVA, raise the issue of DVA • Be non-judgemental, compassionate, and caring when questioning about abuse • Be confident and comfortable asking about DVA and ask questions in a caring manner'. However, questions may need to be phrased carefully as 'how are things at home?' may not be understood. Instead use, for instance, 'Are you afraid of someone in your home?' • Do not pressure a woman to disclose • Be aware that simply raising the issue of DVA can help a woman because it raises her awareness, and she may begin to feel validated; it also communicates concern • Let the woman know that she can always talk about DVA; later ask whether the woman is fine if you could raise the issue later – not to offend her but as a concern • Explain the impact of DVA on children • Address the consequences of DVA pre-emptively and explain when you must breach confidentiality by informing other parties
Immediate response to disclosure	• Respond in a non-judgemental way, showing compassion, support, and belief in the women's experiences • Acknowledge the complexity of the issues of DVA, be willing to respect the woman's unique concerns and decisions and put her identified needs first • Take time to listen to the woman

	• Provide information and offer referrals and specialist help and services sensitive to the needs of migrant women – here it may be necessary to telephone services on migrant women's behalf and make direct referrals (e.g. to IRIS) because migrant women cannot do this due to lack of language, access to mobile phone, coercive control • Ensure that the women know that they have control over the situation and address safety concerns • Make sure that the women's social and psychological needs (in addition to the medical needs) are addressed • Document the abuse • Debrief with interpreter if needed
Responses in later interactions	• If possible, arrange for the same interpreter (if new interpreter follow procedure as outlined before) • Be patient and supportive and allow the woman to progress at her own therapeutic pace Understand the chronicity of the problem and provide follow-up and continued support o Be aware that a migrant woman may face deportation, precarious situation, homelessness and ostracisation o This may further impact their health Respect the woman's wishes and do not pressure them into making any decisions about changing the situation Be non-judgemental if the abused woman does not follow up referrals immediately Ask if there are any problems accessing services • Be aware that DVA workers are not there 'to get women out of abusive relationships' but to support their decisions • Give the woman an opportunity to disclose at later date

Source: This table is adapted from Feder and colleagues. ((143) p. 36)

This research identified a shortage in the provision of counselling or therapy, particularly for migrant women with language barriers. Social isolation due to migration and/or ostracisation make counselling, therapy or support groups even more important for migrant women. The sessions need to be adequate in number and adequately spaced.

HCPs in clinics, who perform scans and terminations of pregnancies, should be aware that some women are forced to undergo these procedures, particularly if the foetus is female. Appropriate interventions should be in place to inform these women about their rights to free choice.

6.4.4 For policy

This research found that the healthcare response to migrant women affected by DVA needs to be improved, as some migrant women encountered healthcare responses that could have endangered them. This study also underlines the importance of the healthcare sector for migrant women and highlights the need for improving guidelines.

Information about different kinds of DVA available via public health campaigns needs to be accessible for all women – that is they should be provided in many languages, in graphic or music form and through various media channels, such as print (leaflets, posters) and the radio/television to also reach illiterate women. However, given the extreme coercive control some migrant women face, this information might still be inaccessible. If there is

no knowledge as to how to engage with safe online behaviour, this may put women further at risk.

Public information about DVA should address women's fears of the consequences of disclosure (e.g. deportation, loss of children) and these should be raised in healthcare settings. Messages, such as '*nobody deserves to be hit'* and *'you can talk to us'*, may be insufficient as they do not address the normality of DV, self-blame ('*a real woman can change her man*' or '*it's a cross to bear*') and the consequences of disclosure (e.g. deportation (209)). To challenge assumption about DV, the use of proverbs has been suggested. (206, 329) Stressing the intergenerational transmission of violence and its impact on children may motivate women to leave. However, information on its own is insufficient; an appropriate and empathic healthcare response is also essential. There is also an urgent need for information about healthcare and how to register with providers.

To provide 'universal' healthcare and counteract fears of deportation, should not be required to ask migrant women about their passports and inform immigration authorities. (203, 330)

There is a need to address a wide range of perpetrators, including female family-in-law members. Here the intergenerational transmission of violence (due to witnessing and/or experiencing DVA) and re-enactment of their own traumatic experiences (forced marriage, enslavement, forced terminations of pregnancies) should be addressed by also trying to change attitudes and perceptions of DVA and challenge its normality. The wider family may be reached via community groups and English classes. There is a scarcity of such interventions. How far the cultural context model (312) may be useful needs further research.

Reproductive knowledge should be enhanced, and reproductive coercion should be addressed. One current intervention integrated into routine family planning tries to address (331) this; however, it remains unknown whether this is tailored sufficiently to the needs of Asian and perhaps other migrant women (e.g. in both the UK and US). Interventions for Asian and other migrant women may need to promote reproductive knowledge to prevent blaming women for female offspring. As identified in one study, some South Asian migrant women and men may need to be informed that the primary aim of antenatal ultrasound scans is to determine the health of the foetus rather than the sex. (220) Migrant women who are coerced into terminations need to be reached – although this is a complex issue. Migrant women may receive a patriarchal bargain (i.e. increase of power by giving birth to a son), yet at the same time some women reported regret and emotional trauma. (220) However, this finding is *not* meant to suggest any restrictions

regarding migrant women's decision-making. Instead, I want these women to be reached by appropriate interventions so that they can make an informed decision. How this can be done requires further research.

6.5 Chapter summary and conclusion

In this chapter, I have drawn together findings from my qualitative synthesis and interviews and have discussed them in the context of the wider literature and theory. I have discussed the challenges, strengths and limitations of my research, reflected on how my own experiences and identity shaped the research, and have made recommendations for future research, practice and policy.

This is the first synthesis on the healthcare experiences, pathways and needs of migrant women affected by DVA. While there are similarities between non-migrant and migrant women, there are also differences. Migrant women's DVA experiences seem to differ regarding their onset, forms and perpetrators. Migration-specific factors may make migrant women more vulnerable due to multiple dependencies, such as lack of immigration status, resources, and social network. Migrant women's DVA experiences are often intersected with their migration experiences; both can individually impact health, but they also interrelate and may jointly affect help-seeking, healthcare access and use.

Below, I summarise the main findings in relation to my research questions. My questions were:

1) What are the experiences and needs of migrant women with histories of DVA

2) How did these women find support following exposure to DVA?

3) What are unmet healthcare needs?

1) In comparison to non-migrant women, migrant women's healthcare access and experiences were often constrained by additional barriers, such as lack of language provision, knowledge and immigration status, fear of consequences of disclosure, social and socio-political repercussions, such as community ostracisation , and deportation. Communicating about DVA is difficult for non-migrant women, but this was further constrained by additional fears and language barriers. Some migrant women encountered a double disadvantage, fearing judgement and breach of confidentiality when interacting with HCPs from the same country/culture and feeling misunderstood and/or discriminated against by non-migrant HCPs. Inappropriate and harmful healthcare responses included discrimination, breach of confidentiality, silence and focus on symptoms – these were exacerbated by language barriers and 'cultural reasons'.

While some migrant women may prefer talking to healthcare professionals from the same country (or who can speak their language), other women may prefer talking to a non-

migrant healthcare professional with the help of adequate interpreting due to fear of breach of confidentiality or judgement. Whether or not a survivor wants a culturally or linguistically congruent healthcare professional may depend on the healthcare setting (primary care vs mental health). Healthcare was experienced positively when migrant women encountered person-centred care (feeling cared for, listened to non-judgmentally, asked sensitively about DVA and receiving information and referrals). Cultural competency may additionally enhance this due to provision of adequate interpreting and self-reflection.

2) Migrant women often-disclosed DVA when in crisis, due to the severity of violence and/or its health impact on women or children; sometimes, a third party disclosed for these women. Disclosure could be enabled by information. The other prerequisite for disclosure was trust. Healthcare professionals elicited trust by providing person-centred or culturally competent care. In the interviews, help was often found via trusted individuals. Yet disclosure did not necessarily lead to receiving help. Help was not always found in healthcare; instead, it was received via DVA organisations, children's services, police and other agencies.

3) Migrant women wished for person-centred care. This seems to indicate a universal healthcare need. This may be enhanced by providing training in cultural competency to enhance knowledge, reflexivity and the use of interpreters. Migrant women may have additional healthcare needs, as their DVA experiences are often intersected with their migration experiences – which also impact on migrant women's health (e.g. immigration status, social isolation), particularly their mental health. These require a multiagency response and long-term support, due to lack of social network that often buffers the effects of DVA in non-migrant women. Due to multiple fears, migrant women may need to be informed about DVA, laws, effect on their and their children's' mental health and the consequences of disclosure, prior to any disclosure. Healthcare must be accessible for migrant women in terms of adequate language provision and healthcare responses must ensure that they do not put women at additional risk, including the risk for deportation.

I derived a conceptual model of migrant women's help-seeking and help-receiving experiences, taking also the role of healthcare into account. This thesis provides an in-depth, nuanced insight into the healthcare experiences and needs of diverse migrant women. Taken together, my synthesis and interviews advance the current state of knowledge of the healthcare experiences and needs of migrant women affected by DVA so that the healthcare response can be improved.

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Appendices

Appendix 1. **PROSPERO protocol**

Identifying the needs of migrant women exposed to domestic abuse, sources of support and the role of primary care: a protocol for a qualitative meta-synthesis

Nadia Khelaifat, Ali Heawood, Jocelyn Cherry, Gene Feder

Citation

Nadia Khelaifat, Ali Heawood, Jocelyn Cherry, Gene Feder. Identifying the needs of migrant women exposed to domestic abuse, sources of support and the role of primary care: a protocol for a qualitative meta-synthesis. PROSPERO 2014 CRD42014008718 Available from: http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42014008718

Review question

1. What are migrant women's experiences of domestic abuse including support needs?

2. How do migrant women currently find support following exposure to domestic abuse?

Searches

The following databases will be searched: MEDLINE (Medical Literature Analysis and Retrieval System Online), CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsycINFO, EMBASE (Excerpta Medica Database), PubMed and Web of Science. The following sites for grey literature will be searched: OpenSigle, EThOS (Electronic Theses Online Service) and DART (Digital Archive of Research Theses).

The databases (MEDLINE, CINAHL, PsycINFO, EMBASE, PubMed) were chosen as they have a particular focus on health and the Web of Science because it comprises a wide range of interdisciplinary research as well as conference proceedings. The search will be complemented by hand searches of key journals, writing to first authors and examining reference lists.

The systematic search strategy has three main concepts: domestic violence, migrant women and health care. Since there is no universal definition/operalisation for either domestic violence or for migrant women, a combination of MeSH (Medical Subject Headings) terms such as "Domestic violence" and "Transients and Migrants" and other databases' equivalent headings, as well as alternate synonyms, phrases and text word searches will be used. Adjunct searches will be performed where possible. All databases will be searched from inception.

Search strategy

http://www.crd.york.ac.uk/PROSPEROFILES/8718_STRATEGY_20140211.pdf

Types of study to be included

- Empirical qualitative studies (stand alone or discrete components of mixed method studies) employing qualitative methods for data collection and analysis. - Qualitative studies of migrant women with histories of domestic violence and involvement of healthcare professionals. - Qualitative studies focussing on migrant women's experiences (including support needs) regarding domestic violence within health care. Types of studies may include interviews (1:1 interviews, focus groups) and observations. The publication type will include published articles or reports that have undergone some level of peer review, book chapters and dissertations.

Condition or domain being studied

Despite domestic violence (DV) being widespread, it remains under-researched and concealed in the health care setting (Hegarty et al. 2010). Most healthcare professionals (HCPs) have not received any training about DV, consequently making it harder to raise the subject – this is even more problematic when migrant women are affected.

This systematic review will investigate abused migrant women's experiences within healthcare. It will look at the barriers and facilitators encountered for these women. Although domestic violence against women has produced a large body of literature, to date no synthesis of the qualitative research evidence on the support needs of migrant women regarding domestic violence has been conducted. Consequently individual studies face the risk of being lost. This synthesis will be used for a refinement of an existing domestic violence interventions, for instance IRIS (Identification and Referral to Improve Safety: http://www.irisdomesticviolence.org.uk/iris/) aimed at GPs to identify and address migrant women's support needs in the context of primary care.

This synthesis will build on the EMiNA (Evaluation Migrant women's Needs regarding Domestic Violence and Abuse) study, in which key informant interviews with relevant professionals, agencies and migrant women were carried out to explore expectations and needs regarding support and services for abused migrant women and professionals dealing with these women.

Participants/population

- Migrant women who have been exposed to domestic abuse. Migrant women are here defined as as women who: a) were born (i.e. outside the UK); b) were born to non-British (foreign born, no British citizenship/nationals) parents and c) have come to live, for instance, in the UK for various reasons (this includes asylum seekers and refugees).

The inclusion criteria are adopted from Feder et al's (2006) meta-analysis of qualitative studies and comprise the following:

(1) a qualitative design or an embedded qualitative element in the study design, data collection and analysis;

(2) published articles/reports/ dissertations/chapters;

(3) examination of abused migrant women's views regarding their experiences of abuse, healthcare needs and ways of accessing support;

(4) presence of verbal interaction between the researcher and the participants in order to develop first and second order constructs, on which the reviewers will be able to develop third order constructs (see below);

(5) female participants;

(6) participants 16 years and older;

(7) participants report some lifetime experience of DV;

(8) if the study presents (abused) migrant women as a subset, the migrant women's views are discussed separately;

(9) although migrant women from all countries are being studied, there is a restriction in regards to the country of migration, which is restricted to high income OECD countries, which are the following: (1) Australia, (2) Austria, (3) Belgium, (4) Canada, (5) Chile, (6) Czech Republic, (7) Denmark, (8) Estonia, (9) Finland, (10) France, (11) Germany, (12) Greece, (13) Iceland, (14) Ireland, (15) Israel, (16) Italy, (17) Japan, (18) Korea, Rep., (19) Luxembourg, (20) Netherlands, (21) New Zealand, (22) Norway, (23) Poland, (24) Portugal, (25) Slovak Republic, (26) Slovenia, (27) Spain, (28) Sweden, (29) Switzerland, (30) United Kingdom, (31) United States;

(10) no language restriction.

The exclusion criteria include the following:

(1) randomized control trials;

(2) cohort studies;

(3) case-control studies;

(4) cross-sectional studies;

(5) clinical case studies;

(6) surveys;

(7) surveys with written open-ended questions;

(8) participants younger than 15 years;

(9) non-migrant women (e.g. ethnic minority women or second generation migrant women who have been born and raised in the country of migration);

(10) and participants (migrant women) with no history of domestic violence.

However, when the above named studies (i.e. randomised control trials, cohort studies, case-control studies, cross-sectional studies, surveys, and surveys with written open-ended questions) include a qualitative component; these studies are potentially eligible for inclusion.

Intervention(s), exposure(s)

Studies looking at interventions for abused migrant women within healthcare is not an explicit inclusion criterion, but if there are any these will be included as they will provide insight into abused migrant women's experiences of abuse, their healthcare needs and current ways of accessing support.

Phenomena of interest:

The views of abused migrant women regarding their experiences of abuse, healthcare needs and current ways of accessing support.

Comparator(s)/control

Not applicable.

Primary outcome(s)

Phenomena of interest:

- Abused migrant women's accounts of their experiences of domestic violence, their support needs and current ways of seeking support.

- Migrant women's perceptions of barriers and facilitators to accessing healthcare.

The findings will be used to design additional domestic violence training (e.g. IRIS training), which will assist healthcare professionals in helping affected migrant women.

Secondary outcome(s)

None.

Data extraction (selection and coding)

Two reviewers (NK, JC) will independently assess titles and abstracts of identified records to determine eligibility using the above stated inclusion and exclusion criteria. Irrelevant titles and abstracts will be discarded. If a reference is considered to be of relevance by at least one reviewer, then the full text will be assessed.

Initially, the screening criteria used by, for instance, Malpass et al. (2009) and Campbell et al. (2003) will be applied to potentially relevant studies. This consists of two simple questions: 'Is this qualitative research?' and 'Is this study/paper relevant to the meta-synthesis?' Employing an iterative approach, the identified papers will be read and re-read to decide if they cover data useful to the aims of this review.

Disagreements between reviewers will be resolved by discussion. If the reviewers are unable to resolve disagreements they will seek opinion of the first reviewer's PhD supervisors (AH/GF). Studies will only be included if they have quotes from migrant women about their experiences (and support needs) that would be useful for this meta-synthesis.

Data extraction and management:

The study data will be independently extracted by two reviewers (NK, AH) using a standardised data extraction form. Any differences in data extraction between reviews will be resolved through discussion. Two types of data will be extracted:

1)The experiences and needs described directly by migrant women as expressed in verbatim quotes in the papers (first order constructs).

2) The authors' interpretations or conclusions of the papers (second order constructs) representing their theorisation of themes and conceptualisations derived from the data in the study.

Risk of bias (quality) assessment

Included studies will be assessed for quality using a modified version of the 10 point CASP (Critical Appraisal Skills Programme) scale. Drawing on Feder and colleagues' (2006) finding that a system of weighting the CASP scoring and then ranking the studies by score was relatively insensitive to which of four weighting systems had been employed, a simple score of the studies utilizing the 10 point CASP instrument and ranking according to score will be used. All relevant studies will initially be included in the synthesis and a later sensitivity analysis will determine whether removal of poorer quality studies impacts the synthesis findings, for example, alters the resulting third order constructs and expression of the synthesis.

Strategy for data synthesis

The data will be synthesised drawing on the approach described by Feder et al. (2006) as meta-analysis and the methods of meta-ethnography (Noblit and Hare 1988), as used in other syntheses in the health field (Malpass et al. 2009, 2008 Britten et al. 2002). For this, first, second and third order constructs will be identified. First order constructs are migrant women's experiences and support needs as reported in the papers. The process of translation across the studies follows the identification of second order constructs (i.e. authors views and interpretations of migrant women's experiences and needs), which then enables the research team to create third order constructs (the views and interpretations of the synthesis team). There are various possible types of synthesis (e.g. line of argument, reciprocal, refutational) according to Noblit and Hare (1988). We will develop the most appropriate synthesis, depending on the papers synthesised.

Analysis of subgroups or subsets

Included studies will be assessed for quality using a modified version of the 10 point CASP scale. Drawing on Feder and colleagues' (2006) finding that a system of

weighting the CASP scoring and then ranking the studies by score was relatively insensitive to which of four weighting systems had been employed, a simple score of the studies utilizing the 10 point CASP instrument and ranking according to score will be used. All relevant studies will initially be included in the synthesis and a later sensitivity analysis will determine whether removal of poorer quality studies impacts the synthesis findings, for example, alters the resulting third order constructs and expression of the synthesis.

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Conflicts of interest

None known

Language

English

Country

England

Stage of review

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Subject indexing assigned by CRD

Subject index terms

Domestic Violence; Emigration and Immigration; Ethnic Groups; Humans; Women

Date of registration in PROSPERO

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Revision note for this version

Minor textual edits.

Details of any existing review of the same topic by the same authors

Not applicable.

Stage of review at time of this submission

The review has not started

Stage	Started	Completed
Preliminary searches	Yes	No
Piloting of the study selection process	Yes	No

Stage	Started	Completed
Formal screening of search results against eligibility criteria	No	No
Data extraction	No	No
Risk of bias (quality) assessment	No	No
Data analysis	No	No

Revision note

Minor textual edits.

Versions

26 February 2014

07 March 2014

Appendix 2. **List of search terms**

Evidence synthesis - Search history for:

Identifying the needs of migrant women exposed to domestic abuse, sources of support and the role of primary care: a protocol for a qualitative meta-synthesis

Source	No of hits	After deduplication before importing to EndNote*	Total
MEDLINE (Medline In-process - Current week, Medline 1950 to present, Old Medline 1950 to 1965) 18/02/2014	561	Within MEDLINE = 1	560
Embase (1974 to 2014 February 14) 18/02/2014	750	Within Embase = 20	1290
PSYCHINFO (1806 to February Week 2 2014) 18/02/2014	564	Within PsychInfo = 0	1854
CINAHL (from inception) 19/02/2014	606		2460
WOS/WOK WOS AND Conference Proceedings Citation Index- Social Science & Humanities (CPCI-SSH) -1990-present 19/02/2014	939		3399
PubMed (from inception including in progress) 20/02/2014	2128		5527
		21	
After automatic deduplication in EndNote (author, year, title, journal) = 2526			
TOTAL			**3001**

*De-dupe was author, title, journal, volume and page.

Database: MEDLINE (3 sources: Medline In-process - Current week, Medline 1950 to present, Old Medline 1950 to 1965) 18/02/2014

Search #	Medline 3 sources: Medline In-process - Current week, Medline 1950 to present, Old Medline 1950 to 1965	Hits
1	Domestic Violence/ or Spouse Abuse/ or Battered Women/ or Family Violence/	10682
2	(Domestic violen* or domestic abuse).tw.	4057
3	(abus* adj3 (wom#n or partner or spous* or wife or wives or husband* or famil*)).tw.	4863
4	(battered adj3 (wom#n or female* or partner or spous* or wife or wives or husband*)).tw.	667
5	(violen* adj3 (wom#n or partner or spous* or wife or wives or husband* or famil*)).tw.	6729
6	(wife battering or wife beating).tw.	133
7	(marital adj3 (violen* or abus*)).tw.	267
8	or/1-7	16401
9	Immigration/ or Emigration/ or Human migration/ or "Transients and Migrants"/ or "Emigrants and Immigrants"/ or Refugees/ or Migrant worker/	37709
10	(immigration or emigration or human migration or migrant* or immigrant* or emigrant* or refugee* or asylum seek* or foreigner* or country of birth or foreign born).tw.	40959
11	(minorit* or ethnically diverse or ethnic minorit* or foreign or non-native or black minority ethnic).tw.	106295
12	(newcomer* or new-comer* or alien* or adoptive citizen* or incomer* or naturali#ed citizen* or temporary foreign worker*).tw.	5880
13	Ethnic groups/	41699
14	(ethnic*).tw.	82840
15	Minority Groups/ or minority group*.tw.	12278
16	Vulnerable Populations/	5415
17	vulnerable population*.tw.	3802
18	or/9-17	262759
19	Health Care/ or health care.tw. or healthcare.tw. or Health Service*/ or health service*.tw. or Primary Health Care/ or Primary Health Care.tw. or Primary healthcare.tw. or Primary care/ or primary care.tw. or Secondary Care/ or (secondary care or secondary health care or secondary healthcare).tw. or Tertiary Care/ or (tertiary care or tertiary healthcare or tertiary health care).tw. or General Practice/ or general practice*.tw. or medical care.tw. or Family health care.tw. or Family healthcare.tw. or Family Practice/ or Family practice*.tw. or Primary Care Nursing/ or Primary Care Nursing.tw. or Community Health Nursing/ or Nursing.tw. or Dental facilities/ or dental facilit*.tw. or Preventive Health Services/	749326
20	Hospital/ or hospitals, community/ or hospitals, general/ or hospitals, group practice/ or hospitals, public/ or hospitals, urban/ or Hospital*.tw. or Ambulatory Care/ or Ambulatory Care.tw. or Emergency Medical Service/ or Emergency Medical Service*.tw. or Emergency Health service/ or Emergency Health service*.tw. or Emergency service*.tw.	900238
21	Mental Health Services/ or Mental Health Service*.tw. or mental health care/ or mental healthcare.tw. or Community care/ or community care.tw. or Community mental health service/ or Community mental health*.tw. or "Psychiatric department, Hospital"/ or Psychiatry/ or psychiatr*.tw. or Psychology/ or psychology.tw. or Rehabilitation/ or rehabilitation.tw.	357135
22	Women's Health Services/ or women's health service*.tw. or Maternal Health Services/ or Maternal Health Service*.tw. or Prenatal care/ or Prenatal care.tw. or Postnatal care/ or Postnatal care.tw. or "Obstetrics and Gynecology department, Hospital"/ or gynecology/ or gyn?ecology.tw. or Obstetrics/ or Obstetrics.tw. or Midwifery/ or midwifery.tw.	99596
23	Health Occupations/ or Health Occupations.tw. or Health care personnel.tw. or Healthcare personnel.tw. or Health personnel.tw. or Healthcare professional*.tw. or health care profession*.tw. or Health Profession*.tw. or health care provider*.tw. or healthcare provider*.tw. or health provider*.tw. or health worker*.tw. or medical profession*.tw. or medical staff.tw. or Physicians, Primary Care/ or Physicians, Family/ or Physician*/ or Physician*.tw. or General Practitioners/ or general practitioner*.tw. or doctor*.tw. or Clinician*/ or Clinician*.tw. or Hospitalists/ or Nurse/ or Nurse*.tw. or Nurse practitioner/ or community health Nurse/ or community health nurse*.tw. or Health visitor*/ or health visitor*.tw. or Nursing staff/ or nursing staff, hospital/ or midwife*.tw. or midwive*.tw. or allied Health personnel/ or community health workers/ or gyn?ecologist*.tw. or Psychologist/ or psychologist*.tw. or Psychiatrist/ or psychiatrist*.tw. or Dentist/ or Dentist*.tw.	947482
24	or/19-23	2342764
25	8 and 18 and 24	561
26	**remove duplicates from 25**	**560**

Database: Embase (1974 to 2014 February 14; 1 source only)
18/02/2014

Search #	Embase (1974 to 2014 February 14)	Hits
1	Domestic Violence/ or Spouse Abuse/ or Battered Woman/ or Partner Violence/ or Intimate Partner Violence/ or Family Violence/	15101
2	(Domestic violen* or domestic abuse).tw.	4912
3	(abus* adj3 (wom#n or partner or spous* or wife or wives or husband* or famil*)).tw.	5899
4	(battered adj3 (woma#n or female* or partner or spous* or wife or wives or husband*)).tw.	112
5	(violen* adj3 (wom#n or partner or spous* or wife or wives or husband* or famil*)).tw.	7908
6	(wife battering or wife beating).tw.	166
7	(marital adj3 (violen* or abuse*)).tw.	347
8	or/1-7	21029
9	Immigration/ or Migration/ or Human migration/ or "Emigrants and Immigrants"/ or Migrant farm workers/ or Refugee/ or Migrant worker/	44765
10	(immigration or emigration or human migration or migrant* or immigrant* or emigrant* or refugee* or asylum seek* or foreigner* or country of birth or foreign born).tw.	47668
11	(minorit* or ethnically diverse or ethnic minority or foreign or non-native or black minority ethnic).tw.	130396
12	(newcomer* or new-comer* or adoptive citizen* or incomer* or naturali#ed citizen* or temporary foreign worker*).tw.	1222
13	Ethnic groups/	53482
14	(ethnic*).tw.	108483
15	Minority Groups/ or minority group*.tw.	13807
16	Vulnerable Populations/	6637
17	vulnerable population*.tw.	4930
18	or/9-17	324489
19	Health Care/ or health care.tw. or healthcare.tw. or Health Service*/ or health service*.tw. or Primary Health Care/ or Primary Health Care.tw. or primary healthcare.tw. or Primary care/ or primary care.tw. or Secondary care/ or (secondary care or secondary health care or secondary healthcare).tw. or Tertiary care/ or (tertiary care or tertiary healthcare or tertiary health care).tw. or General Practice/ or general practice*.tw. or medical care.tw. or Family health care.tw. or Family healthcare.tw. or Family practice/ or Family practice*.tw. or Primary Care Nursing/ or Primary Care Nursing.tw. or Community Health Nursing/ or Nursing.tw. or Dental facilities/ or dental facilit*.tw. or Preventive Health Services/	1039488
20	Hospital/ or Hospital*.tw. or hospitals, community/ or hospitals, general/ or hospitals, group practice/ or hospitals, public/ or hospitals, urban/ or Ambulatory Care/ or Ambulatory Care.tw. or Emergency Medical Service/ or Emergency Medical Service*.tw. or Emergency Health service/ or Emergency Health service*.tw. or Emergency services/ or emergency service*.tw.	1301666
21	Mental Health Service/ or Mental Health Service*.tw. or Mental health care/ or (mental health care or mental healthcare).tw. or Community care/ or Community mental health services/ or Community mental health*.tw. or Psychiatric department/ or Psychiatry/ or psychiatr*.tw. or Psychology/ or psychology.tw. or Rehabilitation/ or rehabilitation.tw.	582556
22	Women* Health Services/ or women's health service*.tw. or Maternal Health Service*.tw. or Prenatal care/ or Prenatal care.tw. or Postnatal care/ or Postnatal care.tw. or "Obstetrics and Gynecology department, Hospital"/ or Obstetrics/ or Obstetric*.tw. or gyn?ecology/ or gyn?ecology.tw. or midwifery.tw.	186262
23	Health occupations.tw. or Health care personnel/ or health care personnel.tw. or Healthcare personnel.tw. or Health personnel.tw. or Healthcare profession*.tw. or health care profession*.tw. or Health profession*.tw. or health care provider*.tw. or healthcare provider*.tw. or health provider*.tw. or Health worker*/ or health worker*.tw. or Medical Profession/ or medical profession*.tw. or Medical staff/ or medical staff.tw. or Physicians/ or Family physicians/ or Physician*.tw. or General Practitioner/ or general practitioner*.tw. or doctor*.tw. or Clinician*.tw. or Nurse/ or hospitalist*/ or hospitalist*.tw. or Nurse*.tw. or Nurse practitioner/ or community health Nurse/ or community health Nurse*.tw. or Health visitor/ or health visitor*.tw. or Nursing staff/ or Midwife/ or (midwife or midwive*).tw. or allied Health personnel/ or community health workers/ or gyn?ecologist*.tw. or psychologists/ or psychologist*.tw. or Psychiatrists/ or Psychiatrist*.tw. or Dentist/ or Dentist*.tw.	1256971
24	or/19-23	3327428
25	8 and 18 and 24	750
26	remove duplicates from 25	**730**

Database: PsychInfo search (1806 to February Week 2, 2014)
18/2/2014

Search #	PsycINFO (1806 to February Week 2, 2014)	Hits
1	Domestic violence/ or Partner Abuse/ or Battered Females/ or Intimate Partner Violence/ or Family violence/	15012
2	(Domestic violen* or domestic abuse).tw.	7628
3	(abus* adj3 (wom#n or partner or spous* or wife or wives or husband* or famil*)).tw.	9413
4	(battered adj3 (wom#n or female* or partner or spous* or wife or wives or husband*)).tw.	2126
5	(violen* adj3 (wom#n or partner or spous* or wife or wives or husband* or famil*)).tw.	11611
6	(wife battering or wife beating).tw.	298
7	(marital adj3 (violen* or abuse*)).tw.	832
8	or/1-7	25948
9	Immigration/ or Human migration/ or Refugee/ or Migrant farm worker/	20312
10	(immigration or emigration or human migration or migrant* or immigrant* or emigrant* or refugee* or asylum seek* or foreigner* or country of birth or foreign born).tw.	29802
11	(minorit* or ethnically diverse or ethnic minorit* or foreign or non-native or black minority ethnic).tw.	53221
12	(newcomer* or new-comer* or adoptive citizen* or incomer* or naturali#ed citizen* or temporary foreign worker*).tw.	1804
13	"Racial and ethnic groups"/	9959
14	(ethnic*).tw.	62187
15	Minority Groups/ or minority group*.tw.	13469
16	vulnerable population*.tw.	2038
17	or/9-16	129316
18	(Health care or healthcare).tw. or Health care services/ or Health care service*.tw. or healthcare service*.tw. or health service*.tw. or Primary Health Care/ or Primary Health Care.tw. or primary care.tw. or (secondary care or secondary health care or secondary healthcare).tw. or (tertiary care or tertiary healthcare or tertiary health care).tw. or general practice*.tw. or Medical care/ or medical care.tw. or Family health care.tw. or Family healthcare.tw. or Family practice*.tw. or Primary Care Nursing.tw. or Nursing/ or nursing.tw. or dental facilit*.tw.	171645
19	Hospitals/ or Hospital*.tw. or Ambulatory Care/ or Ambulatory Care.tw. or Emergency Medical Service*.tw. or Emergency Health service/ or Emergency Health service*.tw. or Emergency services/ or emergency servic*.tw.	121044
20	Mental Health Services/ or Mental Health Service*.tw. or mental health care.tw. or mental healthcare.tw. or community care.tw. or Community mental health service/ or Community mental health service*.tw. or Community mental health*.tw. or Psychiatric Hospitals/ or Psychiatry/ or psychiatr*.tw. or Psychology/ or psycholgy.tw. or Rehabilitation/ or rehabilitation.tw.	299219
21	(Women's Health service* or Maternal Health Service* or Maternal Health Service*).tw. or Prenatal care/ or Prenatal care.tw. or Postnatal care.tw. or Obstetrics/ or Obstetrics.tw. or gyn?ecology.tw. or Midwifery/ or midwifery.tw.	5230
22	(Health occupations.tw. or health care personnel or Healthcare personnel).tw. or Health personnel/ or Health personnel.tw. or Healthcare profession*.tw. or health care profession*.tw. or Health Profession*.tw. or health care provider*.tw. or healthcare provider*.tw. or health provider*.tw. or health worker*.tw. or Medical Personnel/ or Medical Personnel.tw. or medical profession*.tw. or medical staff.tw. or Physician*.tw. or Family physicians/ or General Practitioners/ or general practitioner*.tw. or GP.tw. or GPs.tw. or Doctor*.tw. or Clinicians/ or Clinician*.tw. or hospitalist*.tw. or Nurse*.tw. or Community health Nurse*.tw. or Health visitor*.tw. or Midwife.tw. or Midwives.tw. or Gyn?ecologist*.tw. or Psychologists/ or Psychologist*.tw. or Psychiatrist/ or Psychiatrist*.tw. or Dentists/ or Dentist*.tw.	302940
23	or/18-22	638001
24	8 and 17 and 23	564
25	remove duplicates from 24	**564**

Database: CINAHL via EBSCOhost (from inception)
19/02/2014

Search	CINAHL: from inception; Interface - EBSCOhost	Hits
S1	MM "Domestic Violence+" or "Intimate Partner violence" or " Battered women" or "Family violence"	17,068
S2	(domestic violen* or domestic abuse)	5,943
S3	(abus* N3 (wom?n or partner or spous* or wife or wives or husband* or famil*))	3,122
S4	(battered N3 (wom*n or partner or spous* or female* or wife or wives or husband*))	2,613
S5	(violen* N3 (wom?n or partner or spous* or wife or wives or husband* or famil*))	6,786
S6	(wife battering or wife beating)	62
S7	(marital N3 (violen* or abuse*))	122
S8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7	20,150
S9	MH "Emigration and Immigration" OR "Transients and Migrants" OR "Immigrants" OR "Refugees"	14,049
S10	(immigration or emigration or human migration or migrant* or immigrant* or emigrant* or refugee* or asylum seek* or foreigner* or country of birth or foreign born)	16,205
S11	(minorit* or ethnically diverse or ethnic minorit* or foreign or non-native or black minority ethnic)	25,871
S12	(newcomer* or new-comer* or adoptive citizen* or incomer* or naturali?ed citizen* or temporary foreign worker*)	261
S13	(MH "Ethnic groups")	11,303
S14	(ethnic*)	28,340
S15	(MH "Minority Groups") or (minority group*)	7,507
S16	(Vulnerable Population*)	2,308
S17	S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16	61,738
S18	((MH "Health services") or (Health care or healthcare or Health care service* or healthcare service* or health service*) or (MH " Primary Health Care") or (primary health care or primary care) or (secondary care or secondary health care or secondary healthcare) or (tertiary care or tertiary healthcare or tertiary health care) or (MH "Family Practice") or (MH "Primary Nursing") or (MH "community health nursing") or (MH "Medical Care") or (general practice* or medical care or Family health care or Family healthcare or Family practice* or Primary Care Nursing or Community Health Nursing or Nursing or dental facilit* or Preventive Health Services))	769,672
S19	((MH "Hospitals") or (MH "Ambulatory Care") or (MH "Emergency Medical Services") or (MH "Emergency Service") or (Hospital* or Ambulatory care or Emergency Medical Service* or Emergency Health service* or Emergency service*))	254,405
S20	((MH "Mental Health Services") or (MH "Mental health care") or (MH "Community mental health services") or (MH "Hospitals, Psychiatric") or (MH "psychiatry") or (MH " Rehabilitation") or(Mental Health Service* or mental health care or mental healthcare or Community care or Community mental health* or Psychiatric Hospital* or psychiatr* or Psychology or Rehabilitation))	189,668
S21	((MH "Women's Health Services") or (MH "Maternal Health Services") or (MH "Prenatal care") or (MH "Postnatal care") or (MH "Midwifery") or (MH "gynecology") or (MH "Obstetrics")) OR ((Women's Health Services or women's health service* or Maternal Health Service* or Prenatal care or Postnatal care or Obstetrics and Gyn#ecology or Obstetrics or Midwifery))	39,269
S22	((MH "Health Occupations") or (MH "Health Personnel")or (MH "Physicians") or (MH "Physicians, Family") or (MH "Hospitalists") or (MH "Nurses") or (MH "Nurse practitioners") or (MH "Midwives") or (MH "Nurse practitioners") or (MH "Nursing Staff, Hospital") or (MH "community health workers") or (MH "allied health personnel") or (MH "psychiatrists") or (MH "psychologists") or (MH "Dentists") or (Health occupations or health care personnel or Healthcare personnel or Health personnel or Healthcare profession* or health care profession* or Health profession* or health care provider* or healthcare provider* or health provider* or Health worker* or Medical Profession* or Medical staff or Physician* or Family physicians or general practitioner* or doctor* or Clinician* or Nurse or hospitalist* or Nurse practitioner or community health Nurse* or health visitor* or Nursing staff or midwife or midwive* or allied Health personnel or community health workers or gyn#ecologist* or psychologist* or Psychiatrist* or Dentist*))	438,277
S23	S18 OR S19 OR S20 OR S21 OR S22	1,188,071
S24	S8 AND S17 AND S23	**606**

Database: WEB OF SCIENCE (Social Sciences Citation Index (SSCI) --1956-present)
19/02/2014

Search	WOS: Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All years	Hits
#1	TS=(domestic violen*)	10226
#2	TS=(domestic abuse)	5342
#3	TS=(abus* NEAR/3 (wom?n or partner or spous* or wife or wives or husband* or famil*))	10249
#4	TS=(battered NEAR/3 (wom?n or partner or spous* or female* or wife or wives or husband*))	2501
#5	TS=(violen* NEAR/3 (wom?n or partner or spous* or wife or wives or husband* or famil*))	13797
#6	TS=(wife battering or wife beating)	543
#7	TS=(marital NEAR/3 (violen* or abuse*))	975
#8	#13 OR #12 OR #11 OR #10 OR #9	25924
#9	TS=(immigration or emigration or human migration or migrant* or immigrant* or emigrant* or refugee* or asylum seek* or foreigner* or country of birth or foreign born)	157930
#10	TS=(minorit* or ethnically diverse or ethnic minorit* or foreign or non-native or black minority ethnic)	221471
#11	TS=(newcomer* or new-comer* or adoptive citizen* or incomer* or naturali?ed citizen* or temporary foreign worker*)	3339
#12	TS=(or ethnic*)	126805
#13	TS= (Minority Groups* or vulnerable population*)	27001
#14	#13 OR #12 OR #11 OR #10 OR #9	480469
#15	TS=(Health Care OR Healthcare OR Health Service* OR Primary Health Care OR Primary Healthcare OR Primary Care OR Secondary care OR secondary healthcare OR secondary health care OR Tertiary care OR tertiary healthcare OR tertiary health care OR General Practice* OR Medical care OR Family health care OR Family healthcare OR Family practice* OR Primary Care Nursing OR Community Health Nursing OR Nursing OR Dental facilit* OR Preventive Health Service*)	779400
#16	TS=(Hospital* OR hospitals, community OR hospitals, general OR hospitals, group practice* OR hospitals, public OR hospitals, urban OR Hospital* OR Ambulatory Care OR Emergency Medical Service* OR Emergency Health service* OR Emergency Service*)	614438
#17	TS=(Mental Health Service* OR Mental Health Service* OR mental health care OR community care OR Community mental health service* OR Community mental health* OR "Psychiatric department, Hospital" OR Psychiatric Hospital OR Psychiatry OR psychiatr* OR Psychology OR Rehabilitation)	508797
#18	TS=(Women's Health Service* OR Maternal Health Service* OR Maternal Health Service* OR Prenatal care OR Postnatal care OR "Obstetrics and Gynecology department, Hospital" OR Gyn$ecology OR Obstetric* OR Midwifery)	77979
#19	TS=(Health Occupation* OR Health Care Personnel OR Healthcare Personnel OR Health Care Profession* OR Healthcare Profession* OR Health Personnel OR Health Profession* OR Health care provider* OR Healthcare provider* OR Health provider* OR Health worker* OR Medical Profession* OR Medical Staff OR Physicians, Primary Care OR Physicians, Family OR Physician* OR General Practitioner* OR doctor* OR Clinician* OR midwife OR midwive* OR Hospitalist* OR nurse* OR nurse practitioner* OR Nursing staff OR Community health nurse* OR Health visitor* OR Allied health personnel OR Community health worker* OR gyn$ecologist* OR Psychologist* OR Psychiatrist* OR Dentist*)	694783
#20	#19 OR #18 OR #17 OR #16 OR #15	1938492
#21	#20 AND #14 AND #8	**939**

Database: PubMed (from inception including in progress)
20/02/2014

Search	PubMed Search (from inception including in progress)	Hits
#1	"Domestic violence"[MeSH Terms] OR "Spouse abuse"[MeSH Terms]	34267
#2	Domestic abuse[Text Word]	243
#3	Spouse abuse [Text Word]	5962
#4	Battered women [Text word] or Battered woman [Text word] or Battered female* [Text word]	3108
#5	Partner violence [Text word]	3483
#6	Partner abuse [Text Word]	339
#7	Wife battering [Text word] or Wife beating [Text word]	133
#8	Marital violence [Text word] or Marital abuse [Text word]	132
#9	Family violen* [Text word] or Family abuse [Text word]	1034
#10	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 or #9	36217
#11	"Human migration"[MeSH Terms] OR "Transients and Migrants"[MeSH Terms] OR "Emigrants and Immigrants"[MeSH Terms] OR "Refugees"[MeSH Terms]	37498
#12	Immigration [Text Word] or Emigration [Text Word] or Human migration [Text Word] or Migrant* [Text Word] or Immigrant*[Text Word]or Emigrant*[Text Word] or Refugee*[Text Word] or Asylum seek*[Text Word] or Foreigner*[Text Word] or country of birth [Text Word] or foreign born [Text Word]	58574
#13	minorit* [Text Word] or ethnically diverse [Text Word] or ethnic minorit* [Text Word] or foreign [Text Word] or non-native [Text Word] or black minority ethnic [Text Word]	139722
#14	Newcomer* [Text Word] or new-comer*[Text Word] or adoptive citizen* [Text Word] or incomer* [Text Word] or naturalized citizen* [Text Word]or naturalised citizen* [Text Word] or temporary foreign worker*[Text Word]	1019
#15	"Ethnic groups" [MeSH Terms]	105801
#16	ethnic*[Text Word]	110834
#17	"Minority Groups" [MeSH Terms]	9925
#18	"Vulnerable Populations" [MeSH Terms]	5386
#19	Vulnerable population* [Text Word]	8790
#20	#10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18	336151
#21	Health care[Text Word] OR healthcare[Text Word] OR "Health Services"[MeSH Terms] OR (health service[Text Word] OR health services[Text Word]) OR "Primary health care"[MeSH Terms] OR Primary Health Care[Text Word] OR Primary healthcare[Text Word] OR primary care[Text Word] OR "Secondary care"[MeSH Terms] OR secondary care[Text Word] OR secondary health care[Text Word] OR secondary healthcare[Text Word] OR "Tertiary healthcare"[MeSH Terms] OR tertiary care[Text Word] OR tertiary healthcare[Text Word] OR tertiary health care[Text Word] OR "General practice"[MeSH Terms] OR (general practice[Text Word] OR general practices[Text Word]) OR medical care[Text Word] OR Family health care[Text Word] OR Family healthcare[Text Word] OR (family practice[Text Word] OR family practice*[Text Word]) OR ("Primary nursing"[MeSH Terms] OR "Primary care nursing"[MeSH Terms]) OR Primary Care Nursing[Text Word] OR "Community health nursing"[MeSH Terms] OR Nursing[Text Word] OR "Dental facilities"[MeSH Terms] OR (dental facilities[Text Word] OR dental facility[Text Word]) OR "Preventive health services"[MeSH Terms]	2300226
#22	Hospitals[MeSH Terms] or "Hospitals, community"[MeSH Terms] or "Hospitals, general"[MeSH Terms] or "Hospitals, group practice"[MeSH Terms] or "Hospitals, public"[MeSH Terms] or "Hospitals, urban"[MeSH Terms] or Hospital*[Text Word] or "Ambulatory Care"[MeSH Terms] or Ambulatory Care[Text Word] or "Emergency Medical Services"[MeSH Terms] or Emergency Medical Service*[Text Word] or Emergency Health service*[Text Word] or Emergency service*[Text Word]	1175484
#23	Mental Health Services[MeSH Terms] or Mental Health Service*[Text Word] or mental healthcare[Text Word] or community care[Text Word] or "Community mental health services"[MeSH Terms] or Community mental health*[Text Word] or "Psychiatric department, Hospital"[MeSH Terms] or "Psychiatry"[MeSH Terms] or psychiatry*[Text Word] or "Psychology"[MeSH Terms] or psychology[Text Word] or "Rehabilitation"[MeSH Terms] or rehabilitation[Text Word]	1255353
#24	Women's Health Services[MeSH Terms] or women's health service*[Text Word] "Maternal Health Services"[MeSH Terms] or Maternal Health Service*[Text Word] or "Prenatal care"[MeSH Terms] or Prenatal care[Text Word] or "Postnatal care"[MeSH Terms] or Postnatal care[Text Word] or "Obstetrics and Gynecology department, Hospital"[MeSH Terms] or "Gynecology"[MeSH Terms] or gynecology[Text Word] or "Obstetrics"[MeSH Terms] or Obstetrics[Text Word] or "Midwifery"[MeSH Terms] or midwifery[Text Word]	95417

#25	Health Occupations[MeSH Terms] or Health Occupations [Text Word] or Health care personnel[Text Word] or Healthcare personnel[Text Word] or Health personnel[Text Word] or Healthcare profession*[Text Word] or Health care profession*[Text Word] or Health Profession*[Text Word] or health care provider*[Text Word] or healthcare provider*[Text Word] or health provider*[Text Word] or health worker*[Text Word] or medical profession*[Text Word] or medical staff[Text Word] or "Physicians, Primary Care"[MeSH Terms] or "Physicians, Family"[MeSH Terms] or "Physicians"[MeSH Terms] or Physician*[Text Word] or "General Practitioners"[MeSH Terms] or general practitioner*[Text Word] or doctor*[Text Word] or Clinician*[Text Word] or "Hospitalists"[MeSH Terms] or Nurse*[Text Word] or Nurse practitioner*[Text Word] or Community health nurse*[Text Word] or health visitor*[Text Word] or "Nursing staff"[MeSH Terms] or "Nursing staff, hospital"[MeSH Terms] or midwife*[Text Word] or midwive*[Text Word] or "Allied Health personnel"[MeSH Terms] or "Community health workers"[MeSH Terms] or Gynecologist*[Text Word] or psychologist*[Text Word] or psychiatrist*[Text Word] or "Dentists"[MeSH Terms]or Dentist*[Text Word]	2110446
#26	#21 OR #22 OR #23 OR #24 OR #25	4676995
#27	#10 AND #20 AND #26	**2128**

Appendix 3. **Standardised data extraction form**

Table of 1st and 2nd order constructs.

Review questions:

1) What are the experiences and support needs of migrant women with histories of domestic violence in healthcare?
2) What are the barriers and facilitators to using healthcare and communicating with healthcare professionals (HCPs)?
3) How do migrant women currently find support following exposure to domestic violence?

Please use a new row for each 2nd order construct. Group 1st order construct quotes with their relevant 2nd order construct in the same row.
Copy and use 1st order constructs more than once if they apply to more than one 2nd order construct.
Add rows for additional constructs.
Data (e.g. 2ndorder constructs) from the discussion sections of the papers can be used
Please do include authors' 2nd order constructs for which there are no verbatim quotes (1st order constructs).
Please do include respondent quotes (1st order constructs) for which the authors have not described a 2nd order constructs.
If you have any additional issues with key concepts/themes or any comments or further thoughts, could you please note them in a separate column?

Second order constructs **Authors' labels or phrases for themes/concepts developed in paper** (verbatim text AND location in the paper – Page column paragraph)	**First order constructs** **Respondents' terms used in paper** (verbatim quotes AND location in the paper – Page column paragraph)	**Comments/ further thoughts**

Appendix 4. **Study characteristics**

Author name(s)	Aim of paper (only relevant aim to abused migrant women is stated)	Country	Recruitment setting (e.g., living in the community, a refugee or a mixture)	Method and language of data collection	Method of data analysis and theories used	Sample size – was sample size a sub-sample?	Participants' characteristics and status of relationship	Women's details re country of origin, duration of residence, legal status, English skills	Abuse type, duration (e.g. lifetime or recent abuse) and perpetrators	Contact with clinician and type of clinician
Rodriguez et al 1998a (202)*	To identify any provider-related factors that may affect patient-provider communication	US, San Francisco Bay Area	Via community based DV organisation; not stated	Semi-structured focus groups; yes, mostly: 2 in Spanish, 1 in Mandarin & Cantonese & 1 in English	Analysis according to themes; not stated	N=28*, no	Median age: 35 yrs; formal educational background ranged from none to university level; 85% had children; 85% divorced, separated and single participants	14 Latina women from Mexico, El Salvador, Guatemala & Colombia; in the US for 1-15 yrs; 14 Asian women from China, Vietnam, Korea and the Philippines and Taiwan; in the US for 1-22 yrs	DV within the previous 2 yrs by husband	Not stated
Rodriguez et al 1998 b (203)*	To explore abused migrant women's' experiences with and perspectives on medical care	US, San Francisco Bay Area	Via community based DV organisation; not stated	Semi-structured focus groups; yes, mostly: 2 in Spanish, 1 in Mandarin & Cantonese& 1 in English	Analysis according to themes; not stated	N= 28*, yes from n=40	Age range: 22-60 yrs, formal education: from none to university (median of total sample 12 years), 78% had children; not stated	14 Latina women from Mexico, El Salvador, Guatemala & Colombia; in the US for 1-15 yrs; 14 Asian women from China, Vietnam, Korea and the Philippines and Taiwan; in the US for 1-22 years	DV within the previous 2 yrs by husband	Not stated
Peckover 1998 (205) (PhD thesis)**	To explore the views and experiences of women survivors of domestic violence in relation to the practices of health visitors	UK, not stated	Via organisations providing support to women experiencing DV; mixed:1 woman still at refuge; 2 women rehoused	Semi-structured interview; yes, 1 interview was conducted in both English & Urdu	Qualitative data analysis, using elements of Grounded Theory; feminist poststructuralist	N=3, yes (n= 40)	Age not given; all had children; 1-2 children; children were aged between 1-10 yrs (all living with mothers); separated	Pakistan (n=2), South East Asia (n=1), duration of stay in the UK: 6-8 yrs, for one woman not stated, English was second language, mentions good spoken English for one woman	DV by partners or ex-partners	Health visitors
Bauer et al 2000 (204)*	To present the major social, political and cultural barriers that affected help seeking and patient-provider communications and how theses contexts shape the experiences, perceptions and expectations in interactions with the health care system	US, San Francisco Bay Area	Via urban community centres and shelters; not stated	Semi-structured focus groups; yes, mostly: 2 in Spanish, 1 in Mandarin & Cantonese & 1 in English	Analysis according to themes; not stated	N= 28*, no	**Latina women:** mean age 34.5 yrs; 93% (13/14) had children, no formal education to some college education; **Asian women:** mean age 35 yrs; 71% (10/14) had children; elementary education to completed college education; Latina women: 85% divorced, single or separated	Latina women from Mexico (n=6), El Salvador (n=3), Guatemala (n=2) and Colombia (n=3) who had lived in the US for 2 months-15 yrs (median 6yrs), and Asian women from China (n=5), Vietnam (n=1), Korea (n=2), the Philippines (n=4), and Taiwan (n=2); had lived in the US from 1-22 yrs (median 10yrs)	DV experience within the previous 2 yrs by husband	Not stated
Martinez 2002 (206) (doctoral education thesis) ***	To explore the perception that six poor Puerto Rican migrant women who had been diagnosed with clinical depression, have of their condition of depression and the social factors interacting and influencing their condition	US, Holyoke, Massachusets	Referral via mental health clinic; not stated	Narrative semi-structured open-ended interviews; yes, in Spanish	Not stated; feminist theory	N= 6, no	30-39 yrs; all had children (range of children 2-5 aged 6 to 22 yrs); years in school 0-10, illiterate (n=1); recipients of welfare (n=4) and Supplemental Social Security for Disability (n=2); not stated	Puerto Rico; had lived in the US from 6 months to 18 years	Lifetime physical, emotional violence and sexual violence; most historic abuse (prior migration) by husband/ partner	Not stated
Belknap and Sayeed 2003 (207)	To explore the thoughts and feelings of Mexican American women regarding being asked questions about domestic violence by a health care provider	US, Midwestern US	Via DV agency; not stated	In-depth interviews guided by topic guide and participant observation; yes, in Spanish	Thematic analysis; Leininger's Culture Care theory (ethno-nursing methodology)	N=7, no	19-38 yrs (mean age 30 yrs); all had children (range 1-5 children, average 2 children aged 1-23 yrs), full-time employed (n=2); unemployed (n=5); 3 married but separated, 4 divorced/separated	Mexico; 1-15 yrs in the US	Lifetime DV by husband/ partner	Not stated
Bui 2003 (208)	To examine help-seeking behavior among abused Vietnamese American women to understand factors associated with their decisions to seek help	US, Orange County, California, Boston, Massachusets, Houston, Texas; Lansing, Michigan	Via victim agencies, snowball technique and promotion in radio talk shows; not stated	In-depth semi-structured interviews; yes, n=33 in Vietnamese only	Not stated; Conell's Gender structure model	N=34, no	20-58 yrs (median 40 yrs); majority had children (88%); 76% had children younger than 18 years old; only 3 women (9%) had a four-year college degree; majority worked (71%), most in manual jobs; married or cohabiting boyfriend (n=17); separated/divorced (n=17)	Vietnam; majority came to US as adults (67%); student (n=1), Vietnamese refugees (n=12), as Amerasians (n=4), sponsored by parents or their husbands (n=17); 1 to 28 yrs (median 8 yrs) in the US; American citizenship (n=14), permanent residents (n=13), and legal aliens (n=7); majority low English proficiency (62%)	Lifetime DV, IPV and intimate partner abuse by husband/ partner	Not stated

Kelly 2004 (209)(PhD thesis) **	To improve health care providers' understanding of the health care experiences of battered Latina women	US, northeast coast	Via DV agencies and legal services, mixed some living in shelters, others lived in community	Hermeneutic interviews; yes some, 10 conducted in Spanish with interpreter, 7 in English	Van Manen's approach; Interpretive phenomenology, feminist theory	N=17, no	19-53 yrs; all had at least 1 child (range 1-4 children); years of education ranged from 4-14 yrs; separated from abuser, had separated from abuser from 3 months to 4 yrs	Colombia (n=5), Puerto Rico (n=5), Honduras (n=2), Mexico (n=2), El Salvador (n=2), and Guatemala (n=l); in the US from 2-23 yrs, undocumented (n=8), US citizens from Puerto Rico (n=5), residents (n=4). Spanish primary language (n=13); Spanish-speaking only (n=8), English and Spanish (n=6), only English (n=1)	Lifetime IPV by partner, ex-partner; their most recent abusive relationships had lasted 6 months to 23 yrs	Not stated
Vasconcellos 2005 (210)* (doctoral psychology thesis) ***	To investigate immigrant Latina battered women experiences with the health care system in the US	US, San Francisco Bay Area (California)	Via community-based organisation, not stated	Focus groups; yes, conducted in Spanish	Thematic content analysis; social ecological model	N=32*, no	19-40 yrs; children: 1-4 (range 1 to 4); education: 3.1% had no school, 28.1% had 1st through 7th grade, 15.6% had some high school, 43.8% had high school graduate/GED, and 9.4% some university/vocational school; 3.1% married, 31.3% lived with partner, 6.3% dating, 9.4% single	Mexico (n=27), El Salvador (n=2), Guatemala (n=2), and Nicaragua (n=1); in the US for 3 to 26 yrs	IPV by husband/ partner	Not stated
Perez-Neira 2005 (211)* (doctoral psychology thesis), ***	To explore how immigrant Latina women who had been exposed to IPV perceived mental health and what they expected from mental health services	US, San Francisco Bay Area (California)	Via organisation for Latina women; not stated	Focus groups; yes, in Spanish	Content analysis; ecological theory framework	N=32*, no	19-40 yrs (mean age 30.9 yrs); women had a mean of 2 children (range of children 1-7); 43.8% completed high school, 53.1% married, 31.3% lived with a partner, 6.3% dating and 9.4% were single; 55% currently with abusive partner	Mexico (n=27), El Salvador (n=2), Guatemala (n=2), Nicaragua (n=1); in the US 3 to 26 (mean 9.9. yrs) yrs	Acute histories of IPV (violence occurring in the previous year) and/or lifetime histories of violence by husband or partner	Mental health services
Konczak 2006 (212) (doctoral psychology) ***	To examine Polish immigrant women's perceptions and beliefs about DV, coping strategies, and their attitudes toward mental health services	US, Chicago	Via a Polish American social agency offering DV programme and counselling for victims and offenders; not stated	Face-to face interviews; yes, in Polish	Descriptive phenomenological analysis (Creswell)	N=5, no	30-35 yrs (mean age of 32yrs); 4 women had 1-2 children (aged 2-9); all had university degrees and were employed; all separated, most divorced	Poland; 1-10 yrs in the US from (mean 7 yrs)	Lifetime DV by former or current partner	Not stated
Epstein 2006 (213)***	To explore the experiences of 7 Latina immigrant women who successfully connected with services for IPV at a community mental health agency	US, Northern California	Via community mental health agency (DV support group); not stated	Semi-structured interviews; yes, in Spanish	Framework analysis /thematic analysis; Multicultural theory, feminist theory,	N= 7, no	25-47 yrs; all had children (range of children 2-5); 2-15 yrs of education; employed (n=3), part-time (n=1), unemployed (n=3); living with the abusive partner (n=4) and separated (n=3)	Mexico (n=4), US/Mexico (n=1), Honduras (n=1), Venezuela (n=1); duration living in the US 2-16 yrs	Lifetime IPV duration of abuse: 5-20 yrs	Not stated
Anitha et al 2007 (214) (published report)	To collect data about the mental health needs of South Asian women and their service to contribute to the development of more appropriate, effective and responsive services	UK, Manchester	Via DV agencies; women partly living at refuge; others rehoused in the community (researchers were also current service users or volunteers who had experienced DV)	Semi-structured interviews with questionnaire; yes, 45 interviews conducted in mainly Urdu, Punjabi and Hindi;	Thematic analysis: community participatory project; Community Engagement Model	N= 60, yes from n=80	18-50 yrs; 80% of total sample had children, range of children: 1-6 (majority 2 children); housewives (n=18) or unemployed (n=22), not permitted to work (n=10), FT employment (n=12), PT employment (n=12); retired (n=2), student (n=3), voluntary work (n=2); religion: majority Muslim (n=65) followed by Hindu (n=10), Sikh (n=3), Jewish (n=1), Other (n=1); heterosexual (n=73); family status: divorced (n=12), married (n=33), separated (n=21), single (n=9), widowed (n=5), still in abusive relationship (n=31)	Pakistan (n=56), India (n=11), Bangladesh (n=4) Sri Lanka and Nepal; from Afghanistan (4) who had lived in Pakistan; 1-5 yrs in the UK (n=25), 6-10 yrs in the UK (n=15), 11+yrs in the UK (n=20); British Citizen (n=53), Asylum seeker (n=9), other (n=18); fluent in English (n=28), fluent in Urdu (n=36), fluent in Punjab (n=29), fluent in Hindi (n=6)	DV, including arranged and forced marriage; by partner, former partner or by family members or between family members (72% experienced DV); 72 out of 80 women (90%) reported having endured DV at some time in their life	Not specified
Wilson et al 2007 (215)	To assess the health needs and barriers to healthcare among women with a history of IPV	US, North California	Via IPV crisis centre; women living in shelter/ refuge (n=11) and in community (n=14)	Interviews and survey; yes, also conducted in Spanish	Thematic-identifying key themes; not stated	N=8, yes from n= 25	18-48 yrs (mean age 35yrs); most women had at least 1 child, many, particularly women residing in shelter unemployed and uninsured; women were single, separated/ divorced	Latin America (n=7) Asia (n=1); 30% of all participants were Spanish speaking	Lifetime IPV by a current or former partner/ husband	Not stated

Ahmad et al 2009 (216)	To explore why South Asian immigrant women with experiences of partner abuse delay seeking help from professional	Canada, Greater Toronto Area	Via community-based agencies serving immigrants; not stated	Focus groups using open-ended discussion guide; yes in Hindi	Thematic analysis using constant comparison techniques; feminist, critical - emancipatory perspective	N= 22; no	29-68 yrs; (mean age 46 years); almost all participants had children; majority reported at least high school education; 1/3 employed in the last year; 2/3 were separated or divorced (married (22.7%), separated (45.5%), divorced (22.7%), widowed (9.1%);	India (68.2%, n=15), Pakistan (27.3%, n=6), Bangladesh (4.5%, n=1); 14.3. mean yrs lived in Canada; women perceived their English language ability and social support (in Canada) as 'fair'	Partner abuse in current or previous intimate relationship; husbands, but also by family-in-law mentioned; not stated	All women had a regular family physician; most (77%) were male; 81.8 % visited a health facility in last year
Montalvo-Liendo 2009 (217)	To understand Mexican American women's experiences of IPV and factors that facilitates or hinder decision to disclose abuse	US, South Texas – adjacent to US-Mexico border	Via DV agencies, interviewed at shelter (n=9) and outreach agency (n=10)); both in shelter/refuge and community	In-depth interviews with semi-structured interview guide; open-ended approach, yes in Spanish or English	Grounded theory (Charmaz) and ethnography approach	N=19; yes, from n=26	19-44 yrs; only states the total no. of 52 children in the sample of migrant women; education ranged from none to college education (majority had grade school n=15); the majority were housewives (n=12), employed (n=5); unemployed (n=1); Catholic (n=15), Protestant (n=4); Single (n=2), married partner (n=3), married (n=8), separated (n=4), divorced (n=1 pending), widowed (n=1)	Mexico, residing in the US illegally (n=12); 13 participants stated that their abusive partner was US born, low overall acculturation assessed with shortened version of the Short Acculturation Scale for Hispanics (SASH)	Intimate partner abuse (IPA); lifetime abuse; husband, partner, previous partners/ husbands	Not stated
Shirke et al 2009 (218) (unpublished report/article)	To explore experiences of south Asian women survivors of DA, the perceived impact of these experiences on their physical and mental health, and the barriers that exist to seeking help from services in an English inner-city area	UK, East London	Via refuge; residents of a refuge/shelter	In-depth interviews; yes, mostly, in Sylheti (n=4), in Punjab (n=1), English with support from Hindi speaking refuge worker (n=1)	Thematic content analysis; Not stated	N=7; no	19-32 yrs; children: none to 1-3; separated	Bangladesh (n=4), India (n=2), India/Kenya (n=1): not stated how long they had lived in the UK	Domestic abuse by husband and family-in-law.	Not specified
Belknap and VandeVusse 2010 (219)	To develop a contextual understanding of the lives of immigrant women to inform program development and to address the community's needs for DV services	US, Midwestern US city	Via a DV shelter; not stated	Through listening sessions: yes, in Spanish	Content analysis using a classic approach (Krippendorf, 1980), community based participatory design	N=16; yes from 24 (questionnaire); yes, from n=63 (subsample),	31-40 yrs; 94% (n=59) all had children (2.5 per participant), aged 0-17 yrs (mean age 6 yrs); 21 were employed outside the home; 33% married, 22% living with partner; 27% divorced	Primarily from Mexico (n=51), followed by Puerto Rico (n=7), duration in the US from 1-15 years with the majority for less than 3 yrs; limited English skills; Spanish 1st language for all the participants; for four women, it was not stated where they came from	Intimate partner violence by husband/ partner	Not specified
Puri et al 2011 (220)	To explore immigrant Indian women's narratives about the pressure they face to have sons, the process of deciding to utilize sex selection technologies, and the physical and emotional health implications of both son preference and sex selection	US, California, New York, and New Jersey	Via clinics (78%) or through snowball sampling (22%); not stated	Semi-structured in-depth interviews; yes, interviews in Punjabi, Hindi and English,	Not stated; not stated	N=65, no	19-44 yrs (mean age 31 yrs); an average of 2 children (n=62 had only girls); completed high school (n=38), completed college (n=12), advanced degrees e.g. in medicine or law (n=15); approx. 50% held jobs outside the home; religion: Sikh (n=42), Hindu (n=14), Jain (n=8), Muslim (n=1); health insurance: uninsured self-pay (n=21); Medicaid/Medi-Cal (n=23), private insurance (n=21); all in relationship	India; not stated how long they had lived in the US	Reproductive coercion: different forms of pressure to have sons; ranged from verbal to physical abuse; female in-laws and husbands; no duration was given	Not stated
Nicolaidis et al 2011 (221)	To understand Latina women's beliefs, attitudes, and recommendations regarding depression with a special focus on the impact of gender, ethnicity, violence, and other social stressors	US, not stated	Via community partners; not stated	Focus groups; yes, in Spanish	Thematic analysis; community-based participatory research approach	N=28, yes from 31 (i.e. 92% of total sample were foreign-born)	19-48 yrs (mean age 33.9 yrs); 68% less than high school, high school 16%, some college 3%; employment: 58% unemployed, 3% working or studying full-time, working or studying part-time 10%; insurance: 10% private, 32% Medicare/Medicaid, 48% no insurance; 55% currently with abusive partner	Foreign-born 92%, from primarily Mexico (83%), Central America (6%), Spanish Caribbean (3%); 1.43-43 (mean 16 yrs) yrs in the US, spoke Spanish	Lifetime physical, emotional and/or sexual IPV by partner/husband	Not specified
Rivas 2011 (222) PhD thesis)**	To explore the perceptions, experiences and relational interactions of women with current	UK, inner London	Via primary care practices, community groups and by adverts and	Semi-structured interviews no, in English only	Grounded theory - Charmaz Gillis' and	N=9, yes, from n=32	Characteristics not discernible	Caribbean and African countries	Lifetime psychological violence by husbands/partne	Not specified

	psychological abuse from intimate partners, considering social and cultural context		snowball sample; in the community		Smart's work Goffman'				rs; ongoing abuse	
Al-Habib 2011 (223) (thesis)**	To explore the experiences of women who have been abused by their partners, and the views they hold about seeking help	UK, various English cities	Via Saudi Arabian embassy (using the socio-demographic information women provided in the survey); purposefully sampled; not stated	Semi-structured interviews; yes; 13 in Arabic, 7 in English	Thematic analysis (inductive approach; ecological model	N=20, no	24-63 yrs; 8 women had children, no. of children ranged from 1-7, 4 were pregnant; in the UK to continue their postgraduate studies (n=14), accompanied their partners who had scholarships (n=6); married (n=17); divorced/separated (n=3)	Saudi Arabia; 11 months to 10 years in the UK; 7 interviews conducted in English	IPV, Marriage of majority of participants were 'arranged', husbands/partner, family-in-law	Not specified
Baird 2012 (224) PhD thesis) **	To explore women's experiences of domestic violence before, during and after pregnancy	UK	Via women's DV support service agencies; not stated	Unstructured interviews	Reinharz experiential data analysis framework, phenomenological study, feminist content analysis	N= 2, yes from n=11	36 & 38 yrs; both had children (2/3 children aged 13 months to 10 yrs), university degrees and employed (n=2); widowed (n=1), separated (n=1)	Indonesia; not specifically stated	DV by husband; length of time in abusive relationship: 3 and15 yrs	Not specified
Shuman 2014 (225), doctoral thesis***	To better understand help-seeking behaviors, motivations, and experiences of undocumented Spanish-speaking immigrants	Philadelphia, USA	Via a community health centre that serves uninsured Spanish speaking migrants	Semi-structured individual interview in Spanish	Grounded theory Charmaz (2008); using Liang's framework of help-seeking	N=5	Not stated	Mexico (n=5), undocumented and Spanish-speaking	IPV (physical and emotional)	Not specified
Godoy Ruiz 2015 (226)	To examine the perceived mental health effects of IPV in Latin American immigrant and refugee women	Greater Toronto, Canada	Via advertisements in waiting areas of Latin American psychiatrist, therapists and community agencies serving Latin American communities	Open-ended semi-structured interview; in Spanish	Thematic content analysis; guided by post-colonial feminist intersectionality and ecological framework	N=12	Aged 30-60 yrs, separated (n=6); married, re-married or in common law unions (n=4), single (n=2); university education (n=3), most on low income p. 1774	Mexico (n=4), Peru (n=2) Guatemala (n=1), El Salvador (n=1), Honduras (n=1), Colombia (n=1), Argentina (n=1), Dominican Republic (n=1); duration of stay from more than 20 years ago to arriving in the 2000s	Physical, sexual and psychological IPV, lifetime (n=7) and in the last year (n=5) (but also by female in-laws)	Not specified, mental healthcare?
Parson et al 2016 (227)	To do a preliminary analysis of the mental and physical health issues and barriers to help seeking for immigrant Spanish-speaking women who suffer GBPV	USA, New Jersey	Via women's DV agencies and events	Interviews (=3) and life history interviews (n=10) not stated if conducted in Spanish	Coding ground-up and top-town?	N=13, from a greater study sample including family and friends and professionals	Lack of summary for participants given apart from nationality No ages stated, some had children but not overall stated	Mexico (n=5), Puerto Rico (n=2), Dominican Republic (n=4), born in Colombia but raised in Venezuela (n=1), Nicaragua (n=1)	Gender based partner violence among immigrant women (GBPV)	Not specified;
Garnweidner-Holme et al 2017(228)	To explore how women from different ethnic backgrounds experienced IPV and what their recommendations were about how midwives should communicate about IPV in antenatal care	South East Sweden	Via women's DV crisis shelter; not stated	Semi-structured interviews; one with an interpreter	Thematic analysis according to Braun & Clarke	N= 5, yes from n=8	No ages stated, all women had children, 1-2-3 children aged 1-10 (where stated one woman didn't want to state the age)	Iraq (n=1), Turkey (n=1), Pakistan (n=1), Poland (n=1), Spain (n=1)	IPV by husband during pregnancy	Midwifes/Antenatal care
	Total sample size of all the included women					N=424				

*These publications are based on the same study (i.e. Rodriguez et al, Rodriguez et al Bauer were based on the same study and Perez-Neira and Vasconcellos were based on another study).
** These publications are PhD theses.
2* These publications are doctoral theses mostly in clinical psychology; thus, these theses were based on research carried out and completed as part of their degree but instead of a PhD is was not the only one and this written component was in its duration and scope (and word limit) probably more comparable with a Master's thesis.

Appendix 5. **Overview of constructs**

	Construct	**Construct definition**	**High quality scoring CASP papers= 8 or more**	**Lower quality scoring CASP papers= 7 or less**
1	Constrained help-seeking and help-receiving	Help-seeking and help-seeking was constrained by many barriers.		
	Constrained help-seeking	Seeking healthcare without disclosing DVA due to many barriers	(202-205, 207, 209, 212, 214-218, 220-226, 228)	(208, 211, 219)
1.1.	Healthcare access barriers due to lack of resources	Barriers to accessing healthcare due to lack of various resources		
1.1.1	Lack of knowledge	Lack of knowledge about a) DV due to cultural values and gender roles/pressure b) the resources e.g. laws, organisations c) healthcare and how to navigate it, including primary care, related to lack of immigration status	a) (202, 204, 212, 213, 216, 222, 223, 228) b) (204, 209, 212, 213, 216-218, 222, 223, 225, 227, 228) c) (209, 210, 215, 221)	a) (211) b) (208, 211, 219) c) (211)
1.1.2	Financial, legal and other barriers	a) Lack of insurance/ cost of healthcare, immigration status b) Location and provision of (mental) healthcare c) Lack of childcare d) Long waiting time	a) (209, 210, 215, 221) b) (206, 214) c) (210, 214) d) (204, 209, 210, 226)	a-e) (211) d) (219)
1.1.3	Late help-seeking	Women often sought help late for health problems related to DVA	(209, 212, 216, 217)	
1.2.2	Feelings of shame and other emotional responses to DVA	a) Emotional responses such as shame and self-blame were barriers to disclosure which were influenced by cultural values impacted coping strategies b) depression acts as a barrier to seeking help c) spare family suffering or avoid interference	a) (202, 204, 207, 209, 212-216, 218, 220, 222, 223, 226, 228) b) (227) c) (209, 212, 217, 223)	a & c) (208, 211)
1.2.3	Lack of social support: pressure and coercive control	Lack of social support instead pressure and coercive control, was a barrier to disclosure a) unsupportive/ lack of social support b) instead overt or covertly pressuring women into staying/ complicit abuse	a) (202, 204, 206-209, 211-213, 216, 218-220, 222-224, 226, 228) b) (209, 212-214, 216, 218, 220, 222, 223, 226)	a & b) (208, 211)

1.2.4	Fear of consequences of disclosure	There were many fears regarding consequences of disclosure, which included a) retaliation, b) fear of breach of confidentiality by HCPs: bi) to husband/family bii) to immigration authorities (leading to deportation) biii) to child welfare services (leading to loss of children), biv) to the police c) financial consequences of separation, including becoming homeless d) fear of judgement e) fear of DVA not being validated/not believed f) fear that there will be no helpful response after disclosure g) double disadvantage fearing breach of confidentiality and lack of understanding	a) (204-206, 209, 212, 213, 217, 218, 223-226) b)(202, 204, 209, 214, 217, 218, 223, 224, 226) bi) (214, 216, 218) bii) (204, 209, 212, 215, 217, 218, 224-227) biii) (202-204, 206, 209, 225, 228) biv) (203, 204) c) (204, 209, 212, 213, 216, 223, 227) d) (202, 204, 209, 214, 216, 222, 223) e) (202, 209, 212, 214, 216, 221-223) f) (228) g) (214, 216)	a) (219) b) (208, 211) c) (211)
1.2.5	Healthcare expectations	a) DVA not an issue to be broached in the medical setting, particularly psychological abuse due to extrapolation b) Healthcare and counselling for white women c) HCPs expectations spanned from distant to compassion care ci) Expectation of midwives to rely on them, to make them feel safe and provide guidance cii) healthcare expectations may be related to acculturation d) only contact	a) (202, 204, 207, 209, 212, 214, 216, 221-224) b) (222) c) (205, 209, 210, 217, 222, 223) ci) (228) cii) (209, 210, 217, 222) d) (209, 222, 228)	a & c) (211)
1.3	Constrained help-receiving			
1.3.1	Time constraints	Time constraints and rushed behaviour were perceived negatively – as a lack of interest and care	(207, 209, 210)	
1.3.4	Discrimination	Discrimination experienced based on a) language barriers b) racial prejudice c) immigration status or d) insurance or payment status lack of insurance	(204, 206, 209, 210, 214-217, 221) a) (204, 209, 210) b) (204) c) (204, 206, 210, 217, 221) d) (215, 221)	a & b) (211, 219)

1.3.2	Language barriers and lack of language provision	Language barriers and lack of language provision created major obstacles for communication between abused migrant women and HCPs. This was due to: ai) paucity of interpreters aii) interpreters were difficult to obtain and this aiii) affected waiting times aiv) HCPs attempt to enquire about or screen women for DVA were not (immediately) understood. When interpreters were used, b) they often created a barrier which inhibited trust and talking about DVA c) women were concerned about confidentiality and whether translation was adequate d) perception of rushing, insensitive uncaring e) male interpreters impeded communication f) overall negative perception of interpreters	(202, 204-207, 209, 210, 212-218, 221, 223-225, 228) ai) (205, 214) aii) (202, 204) aiii) (202, 204, 209, 210) aiv) (209, 225) b) (204, 206, 209) c) (204, 206, 209) d) (209) f) (202, 204, 206, 209, 210)	(208, 211, 219) a) (211) b & e) (211) aiii) (211) e) (211)
1.3.5	Inadequate healthcare responses	Focus on physical injuries or symptoms only without asking about DVA, which was perceived as a) missed opportunity After disclosure women encountered b) silence bi) minimising women's distress/ behaviour or responses show lack of understanding bii) focus on medication without explaining diagnosis/medication c) pressuring women to disclose /judgemental advice ci) powerless after disclosure d) unsafe and dangerous practice e) HCPs breached confidentiality	(202, 205, 206, 209, 214, 221, 222) a) (202, 205, 206, 209, 214, 217) b) (202, 214) bi) (209, 214) bii) (202, 206, 214) c)(202, 204, 209, 216, 223, 226) ci) (228) d) (208, 216, 224) e) (216)	a) (211) b) (208) c) (211) d) (208) e) (208)
2	Triggers and conditions for disclosure and pathways to support			

2.1	Violence severity of violence and its impact on women and children	a) Severity of violence and its health impact on women and children triggered disclosure ai) mothering role aii) late help-seeking b) hit rock bottom/crisis c) wanting to unburden/find help d) depletion of coping skills e) document injuries/alert authorities o f) disclosure by third party due to severity of violence g) question about DVA	a) (202, 209, 212-214, 216, 217, 221-225) ai) (204, 206, 209, 212-214, 216, 218, 223, 224) aii) (209, 212, 213, 216) b) (206, 212, 213, 216, 224) c) (216, 217, 223) d) (216) e) (223) f) (209) g) (216, 217, 224, 225)	a) Perez? ai)Perez? f) (208)
2.2	Information and advice received or needed to disclose	a) Providing information about DVA and sources of help and safety strategies b) Information provided in native language bi) Information anonymously needed (e.g. in forms of cards) c) information about the effect on children (including unborn) desired	a) (209, 214, 224, 227, 228) b) (209, 227) bi) (228) c)(228)	
2.3	Trust	Trust was needed for disclosure a) this was elicted by person-centred care in the healthcare encounter and b) continuity of care (i.e. multiple encounters with the same HCP)	(202, 206, 207, 209, 213, 214, 216, 228) a) (202, 207, 209, 213, 216) b) (202, 206, 207, 209, 213, 214)	
2..4	Pathways to support via/in healthcare		(202, 206, 209, 213, 214, 225)	
3	Person-centred care experienced and needed	Patient-centred care was found important it a) facilitated disclosure by eliciting trust and/or b) was a (continuous) response to disclosure of DVA or was an c) unmet need	(202, 204, 206, 207, 209, 210, 213, 214, 216, 222) a) (202, 206, 207, 209, 213, 214, 216, 222) b) (202, 206, 209, 213, 214, 216, 222) c) (202, 204-207, 209, 210, 213, 214, 216)	(208, 211)
3.1	Showing care and concern/ emotional support and understanding	Providing emotional support – highly important as a) a facilitator and/or b) a response to disclosure or c) desired Emotional support and understanding could be (ci) cultural/linguistic, (cii) and/or gendered or (ciii) specific to DVA	(202, 206, 209, 213, 214, 216, 222, 223) a) (202, 206, 209, 213, 214, 216, 222, 223) b) (202, 213) c) (207, 209, 210, 214, 216, 218) (ci) (210, 214, 216) (cii) (214) (ciii) (202)	(208, 211) a) (208) b) (208) ci) (208) cii) (211)

3.2	Communication and listening skills			
3.2.1	Showing an interest in women and congruent non-verbal behaviour	a) Showing an interest in women as persons is perceived as HCPs being caring (e.g. asking about children) b) Displaying congruent non-verbal behaviour	a) (202, 207, 209, 210) b) (202, 206, 207, 209)	
3.2.2	Asking about DVA	a) HCPs tried to find out/unravel the cause of the health symptoms/injuries, which also enabled some women to make the link b) multiple encounters to establish trust (continuity of care) c) going the extra distance d) women wanted to be asked about DVA (unmet need), e) Support for screening not conclusive ei) women wanted to be asked sensitively about DV either eii) directly or eiii) indirectly f) in a manner which could be understood (not how are things at home fi) providing info about DVA and reasons for asking fii) wanting to be asked openly about what DVA is by HCP g) communicating with the midwife about IPV was perceived as more appropriate toward the end of pregnancy, as at the start women felt often overwhelmed with information and needed time to build trust i) more screening/asking about DVA in obstretic setting and greater satisfaction with this when compared to GPs/	a) (202, 206, 213, 214, 216-218, 221-224) b) (202, 206, 207, 209, 213, 214, 216, 228) c) (218) d) (202, 205-207, 209, 210, 213, 214, 216, 218, 223, 228) e) (207, 214, 216) ei) (202, 207, 209) eii) (228) eiii)(207, 209, 210) f) (209) fi) (228) fii) (228) g) (228) i) (214)	d) (208)
3.3.3	Listening skills	Listening skills were central a) a facilitator for and b) a desired response to disclosure bi) to validate feelings c) women appreciated or desired a non-judgemental listener	(202, 206, 207, 209, 213, 216, 217, 221) a) (202, 206, 207, 209, 213, 216, 217, 221) b) (202, 206, 207, 209, 213, 216, 217, 221, 223) bi) (217)	a)(208) b)(208) bi) (208) c) (208) d) (219)

		d) many benefits of being listened to	c) (202, 206, 207, 209, 210, 213, 216, 217, 221-223) d) (202, 206, 209, 216, 217, 221)	
3.3.4	Linguistic and cultural congruence needs	a) Speaking migrant women's native language could facilitate raising DVA b) linguistic and/or cultural congruent HCPs or HCPs from a similar cultural background/country of origin, bi-cultural HCP needed/preferred to overcome language and cultural barriers – bi) particularly in mental healthcare c) fear of judgement or breach of confidentiality by HCP from same culture/country d) HCP could be from a different country speaking the language e) migrant women willing to non-proficient HCP because of personal liking f) Increase of the number of professional interpreters who are also fi) from the same culture	a) (209, 218) b) (206, 210, 216, 221) bi) (214) c) (214, 216) d) (206, 209) e) (209) f) (216)	a & b) (208, 211) f & fi) (211)
3.3.5	Gender congruence	a) Migrant women preferred a female HCP ai) and interpreter; b) no gender preference found or disclosure to male HCP perceived helpful c) women wished to be asked whether they prefer a male or female HCP	a) (207, 214, 216) b) (216, 218, 223, 225)	a, ai & c) (211)
3.4	Information and advice	Information was experienced and/or needed after disclosure about a) DV services and DVA b) free healthcare and support groups c) information on the impact of violence on their own or their children's mental and physical health d) general information about healthcare e) laws against DVA	a) (202, 209, 212, 214, 216, 221, 227, 228) b) (210, 227) c) (214, 221, 228) d) (209, 215) e) (212, 223, 228) f) (209, 212-214)	b) (211)

		f) delay in following up advice/info		
3.5	Need for autonomy and safety	Advice needed of how to keep safe and wanting to preserve autonomy – no wish to find solutions a) not wanting police involvement by HCPs but retain control over decision to involve police b) both fearing and desiring police involvement by HCPs c) use of healthcare as a means of protection d) HCPs to maintain independence from law enforcement agencies	(208, 209, 218, 223) a & b) (203, 209) c) (209) d) (203, 204)	
3.6	Referrals	Referrals were experienced or needed a) to mental health services, including self-support or other mental health groups/ DVA organisations b) Satisfaction with and need for referrals (e.g. mental healthcare/counselling/services), where DVA is addressed and continuity of care and provision of adequate care	a) (202, 212-214, 221, 222, 225, 227) b) (206, 209, 212-214, 222)	f) (211, 219)
3.6.1	Positive experiences within referrals	Benefits of psychotherapy, counselling or self-support a) relief through sharing about IPV and issues deemed otherwise too embarrassing; b) overcoming stigma; c) feeling enabled to help better oneself (e.g. avoiding shelters and finding better work; d) developing strategies to deal with DVA without having to leave the abusive relationship; increased self-esteem e) social support f) Support groups were perceived as a respite where women could safely vent g) while others described being listened to as a cure for their depression	a) (212, 214, 221) c) (222) d) (222) e) (213) f) (213) g) (221) h) (213, 222, 223)	a & b & h) (219)

		h) Within mental healthcare women appreciated the confidential nature of counselling and support groups.		
	Needs in referrals to mental healthcare	Within mental healthcare, migrant women desired a) additional individual therapy b) more sessions c) closely spaced (i.e. not every 14 days) d) continuity of care (i.e. therapy with the same HCP	b) (214) d) (206, 215, 222)	a-c) (211)
3.7	Wider needs	Wider needs often inter-dependent a) navigating the judicial system to obtain independent residency status b) divorce c) finding shelter or adequate housing d) learning the language e) finding a job f) childcare g) establishing a new social network h) integrated social service response	a) (227) b) (227) c) (214, 227) d) (206, 208) e) (227) f) (214, 221) g) (216) h) (227)	

Appendix 6. **Quality appraisal of studies using CASP**

	Rodriguez et al (202)	Rodriguez et al (203)	Peckover (205)	Bauer et al (204)	Martinez (206)	Belknap and Sayeed (207)	Bui (208)	Kelly (209)	Vasconcellos (210)	Perez-Neira (211)	Koczak (212)	Epstein (213)	Anitha et al (214)	Wilson et al (215)	Ahmad et al (216)	Montalvo-Liendo (217)	Shirke et al (218)	Belknap & Vande Vusse (219)	Puri et al (220)	Nicolaidis et al (221)	Rivas (222)	Al Habib (223)	Baird (224)	Shuman (225)	Godoy-Ruiz (226)	Parson et al (227)	Garnweidner et al (228)
Year	1998a	1998b	1998	2000	2002	2003	2003	2004	2005	2006	2006	2006	2007	2007	2009	2009	2009	2010	2011	2011	2011	2011	2012	2014	2015	2016	2017
Total n= 'Yes'	9	9	9	9	9	8	7	10	9	6	9	9	9	9	9	10	10	6	8	9	10	10	10	9	9	8	9
Total n= 'No'	1	1	1	1	0	1	2	0	1	1	1	1	0	1	1	0	0	1	1	1	0	0	0	1	1	2	1
Total n= 'Can't tell'	0	0	0	1	1	1	1	0	0	3	0	0	1	0	0	0	0	3	0	0	0	0	0	0	0	Useful	0
How valuable is the research to this qualitative synthesis? (Key, Useful, Marginal, Not relevant)	Key	Useful	Useful	Useful	Useful	Key	Useful	Key	Useful	Useful	Useful	Useful	Key	Marginal	Key/Useful	Useful	Useful	Marginal	Marginal	Useful	Useful	Useful	Useful	Useful	Useful	Useful	Key
1) Was there a clear statement of aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2) Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3) Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4) Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5) Was the data collected in a way that addresses the research issue?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6) Has the relationship between researcher and participants been adequately considered?	No	No	Yes	No	Yes	No	No	Yes	No	No	No	No	Yes	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes	No	No	No	No
7) Have ethical issues been taken into consideration?	Yes	Yes	No	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8) Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9) Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10) How valuable is the research*?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix 7. **Confirmation of ethics approval**

Nadia Khelaifat

University of Bristol

20th December 2012

Faculty of Medicine and Dentistry

Committee for Ethics (FCE)

University of Bristol Faculty of Medicine & Dentistry,

First Floor South, Senate House,

Tyndall Avenue, Bristol

BS8 1TH

Tel: 0117 331 8197

Dear Nadia

Application number 121319

Title: Cultural sensitive interventions for migrant women affected by domestic violence: how are migrant women currently supported and what is the role of primary care?

Your application has been granted **full ethical approval**. However, please be advised that as your project involves NHS Staff or Premises you must apply for NHS Trust R&D approval before any project activities can begin within that Trust. Once Trust R&D approval has been received you can begin your research.

The FCE expects to be notified of any significant deviations from this research proposal. The FCE also expects to be notified of any unforeseen ethical events which may arise during the course of this study.

On completion of this study the FCE and the peer reviewers would like to see a report of the outcome.

Yours faithfully,

Maria Davies*Chair, Faculty of Medicine and Dentistry Committee for Ethics*

Appendix 8. **Recruitment protocol**

University of BRISTOL

EMiNA (Evaluation of Migrant Women's Needs regarding Domestic Abuse)

Appendix 14: Researcher recruitment protocol for migrant women and professionals

There are different ways the researcher will come into contact with the women and key informants (health care and other professionals) participating in the EMiNA study, which will be outlined in the following.

a) The woman might be first introduced to the study by invitation letter, participant information sheet or by the assessor at the Service. The assessor will seek the woman's written consent for you to contact her (see screening permission ahead of formal consent).

b) However, there might also be the possibility that the woman could be self-selecting; having responded to community based advertisements in groups such as the Freedom programme. Therefore she might instigate the initial contact with the researcher by phoning the researcher's work mobile phone number. This phone has a private voicemail so that potential participants can leave messages at times when the researcher is unavailable to take calls. The message on the answer phone will ask the woman to leave her first name, number and a safe time to phone her.

c) The professionals will receive a covering letter and a participant information sheet to inform them about the study. The researcher will phone them to find out whether or not they are willing to participate and send them the consent form at 48 hours before the interview. There also exists the possibility that professionals will get in touch with the researcher directly.

1. ESTABLISHING INITIAL INTEREST

1.1. INITIAL TELEPHONE CONVERSATION WITH MIGRANT WOMAN

- If the woman consents to be contacted by you, the assessor will phone you in the presence of the woman. The assessor will inform you of;
    - The woman's first name
    - Her safe telephone number
    - Her service user ID number (if one has been assigned)
    - The safe times for you to contact the woman
    - Where she is residing (either in refuge or in the community)
- The phone will then be handed to the woman for her to speak with you directly.
- Introduce yourself to the woman and thank her for agreeing to talk to you.
    - Explain that you would like to interview her after describing the study to her in more detail.
    - If the woman wishes to be interviewed, establish a mutually convenient time and location [redacted]other safe community settings or at the university) to meet with the woman, preferably in the next 24 hours or at the next possible time after this if the service allows a greater time-frame for recruitment. Let her know that this meeting could take up to an hour so that she can schedule in enough time to accommodate it.
    - When you have arranged a time to meet, tell the woman that when you put down the phone she will receive a text from you to confirm the date, time and location of the meeting, which will also let her know your number. Tell her you will text her again on the day of the meeting as a reminder. Explain that she is free to call or text to cancel the meeting if she changes her mind.
- Ask the women to hand the phone back to the worker in order that you can inform them of the outcome of your conversation and if and when you plan to meet.

- Remind the worker to complete the relevant sections of the screening and permission to contact form and return it to the central location in the office.
- If you were unable to arrange an appointment with the woman within the specified time-frame inform the intake worker that the woman will be unable to take part in the study.
- If you have arranged an appointment, let the service manager know.

1.2. IF YOU RECEIVE A RECRUITMENT ANSWER PHONE MESSAGE (VIA ASSESSOR)

- This should tell you the women's first name, her safe telephone number, and a safe time to contact the woman, where she is residing and her client ID number. If any of these details are missing, make contact with the service to establish.
- If the contact number given is a mobile number, before contacting the woman by phone send a text message to the woman reading *'hi this is Nadia from the EMiNA study. I will ring you in 5 minutes to chat. Please let me know if this is not ok'.*
- When making a call follow this protocol, even if the woman has texted back to confirm that she is expecting your call.

    1. Ask *"may I speak with [name]?"* Remember that even if a woman answers she may not be the intended respondent or she may even be the perpetrator of abuse.
    2. If you are asked why you wish to speak to the woman say that it is in relation to a research project. If you are asked what the research entails say it is about women's health. If the phone is not handed over at this point, tell the person that you are unable to discuss the study in anymore detail and inform them that you will ring back on another occasion to talk to [name of woman].
    3. Once you are speaking to the woman you are trying to reach ask *"is it safe for you to talk now?"* If she replies no, tell her you will call back at another time and suggest that she texts you to confirm when this might be. If you have been unable to contact the potential participant within 24 hours inform the service manager who will inform the researcher if more time is available to attempt contact.

4. If she says yes ask her *"are you able to speak freely at the moment?"* If the answer is *'no'* tell her you will call back at another time and suggest that she texts you to confirm when this might be.

5. If you have been unable to contact the potential participant within 24 hours inform the service.

6. If the answer is 'yes' Introduce yourself to the woman and thank her for agreeing to talk to you.

- Explain that you would like to interview her and want to explain the study in more detail to her so that she can decide if she would like to participate.
- Establish whether the woman wishes to be interviewed.
    - If she does, establish a mutually convenient time and location to meet with the woman, preferably in the next 24 hours, or at the next possible time. Let her know that this meeting could take up to an hour so that she can schedule in enough time to accommodate it.
    - Tell the woman that when you put down the phone she will receive a text from you to confirm the date, time and location of the meeting, which will also let her know your number. Tell her you will text her again on the day of the meeting to remind her. Explain that she is free to call or text to cancel the meeting if she changes her mind.

1.3 IF A POTENTIAL PARTICIPANT (WOMAN) CALLS THE RESEACRHER

When a potential participant phones the following steps will be taken:

1. The steps in section 1.2. steps 1-6 (excluding step 5) will be followed to ensure that the participant is willing and able to speak freely.
2. The study screening will be followed to ensure that the participant is eligible for the study:
    - *Are you 18 years of age or over?*
        - If no – ineligible
        - If yes – eligible

- Have you come to Britain from another country?
    - If no – ineligible
    - If yes – eligible
- Have you been or are you currently in a relationship with a partner/husband?
    - If no – ineligible
    - If yes – eligible
- *Have you ever had an admission to a psychiatric hospital?*
    - If no, eligible.
    - If yes: Ask *'What diagnosis did you receive?'*
    - If not psychosis/schizophrenia/bipolar, eligible
    - If diagnosis was psychosis /schizophrenia/bipolar, ineligible. Explain that *'the study we are conducting is not tailored for use with people who have experienced a psychotic episode.'*
- *How have you been feeling recently? Have you been feeling very distressed?*
    - If yes – ineligible
    - If no– eligible

- If the potential participant is ineligible, record their details in the database with the reason for ineligibility e.g. under 16.
- Thank them for their time and interest and let them know that they do not have the particular experience that you are looking for in this study. Offer to signpost them to resources relevant to their situation (helpline numbers, websites etc).

3. If the potential participant is eligible, the researcher will discuss the details of the study with the potential participant, including the reason for the research, what will be required of them, confidentiality and the possible advantages and disadvantages of taking part.

4. If the potential participant is willing to be interviewed, the researcher will set up a time and location for the research interview
5. The researcher will complete participant data form 1 with the potential participant.
6. The researcher will then remind the potential participant of her contact details in case they need to cancel or have any questions. The researcher will also tell the potential participant that she will remind them about the interview (by sending a text message on the day of the interview). The researcher will thank the person for their time.

1.4. IF THE RESEARCHER CALLS THE POTENTIAL PARTICIPANT (FOLLOWING A VOICEMAIL MESSAGE)

The researcher's voicemail message will ask potential participants to indicate when it is safe to call them. The researcher will adhere strictly to calling at the stated times.

When the researcher rings the potential participant the following steps will be taken:

1. The researcher will ask *"may I speak with [name]?"* (the person answering may not be the potential participant and may even be a perpetrator of abuse)

2. If the researcher is asked why they wish to speak to the person, they will respond by saying that it is in relation to a research project. If questioned further the researcher can say that it is about "health and wellbeing". If the phone is not handed over to the potential participant, the researcher will tell the person that they are unable to discuss the study in any more detail and that they will ring back on another occasion.

3. If the researcher is able to speak to the potential participant, they should follow steps 1-6 from section 1.3 and check for eligibility (see above).

- If the potential participant is ineligible, record their details in the database with the reason for ineligibility e.g. under 16.
- Thank them for their time and interest and let them know that they do not have the particular experience that you are looking for in this study. Offer to signpost them to resources relevant to their situation (helpline numbers, websites etc).

7. If the potential participant is eligible, the researcher will discuss the details of the study with the potential participant, including the reason for the research, what will be required of them, confidentiality and the possible advantages and disadvantages of taking part.

8. If the potential participant is willing to be interviewed, the researcher will set up a time and location for the research interview
9. The researcher will complete participant data form 1 with the potential participant.
10. The researcher will then remind the potential participant of her contact details in case they need to cancel or have any questions. The researcher will also tell the potential participant that she will remind them about the interview (by sending a text message on the day of the interview). The researcher will thank the person for their time.

1.5. IF RESEARCHERS CALLS PROFESSIONALS (or vice versa)

- The researcher will explain the study and ask the professional whether or not he/she is willing to participate
- If the professional wishes to be interviewed, establish a mutually convenient time and location (his/her workplace or university premises) to meet with the professional. Let the professional know that this meeting could take up to an hour so that she/he can schedule in enough time to accommodate it.

2. FACE TO FACE MEETING WITH WOMAN

2.1. *Before the meeting*

- The researcher will text the woman on the day of the interview as a reminder (*'Hi, this is Nadia from the EMiNA study. Just a reminder that we have a meeting scheduled for today at x o'clock so that you can take part in the study. Look forward to seeing you)'.*
- The researcher will assemble a recruitment pack consisting of the participant information sheet, the participant support sheet and 2 x consent forms.
- The researcher will obtain a £10 gift voucher to take and, if applicable, sufficient petty cash to cover the reimbursement of the participants travel expenses.
- The researcher will ensure that all equipment is ready and working e.g. digital recorder having sufficient battery life, mobile phone charged etc.
- The researcher will follow the „researcher safety protocol" regarding the „checking-in" system and advance information gathering re venue etc.

2.2. CHECKING ELIGIBILITY

- Introduce yourself to the woman and thank her for agreeing to see you.
- If the woman has been seen by an intake assessor, this person will have screened her for eligibility, however it is still necessary to double check, or if you are in doubt about eligibility, use the following protocol. The same screening procedure applies if the woman contacted the researcher herself.
- Explain that you want to ensure that her health conditions are appropriate for the people taking part in this study so we therefore want to ask a few quick questions before going any further.
    - *Are you 18 years of age or over?*
        - If no – ineligible
        - If yes – eligible
    - Have you come to Britain from another country?
        - If no – ineligible
        - If yes – eligible
    - Have you been or are you currently in a relationship with a partner/husband?
        - If no – ineligible
        - If yes – eligible
    - *Have you ever had an admission to a psychiatric hospital?*
        - If no, eligible.
        - If yes: Ask *'What diagnosis did you receive?'*
        - If not psychosis/schizophrenia/bipolar, eligible
        - If diagnosis was psychosis /schizophrenia/bipolar, ineligible. Explain that *'the study we are conducting is not tailored for use with people who have experienced a psychotic episode.'*

- *How have you been feeling recently? Have you been feeling very distressed?*
    - If yes – ineligible
    - If no– eligible

Ineligible women

- Thank the woman for her time, confirm that they will not be entering into the study but they will continue to access the [redacted] service as usual.
- Record on the study database if a woman is ineligible and the reason why.

2.3. ESTABLISHING INFORMED CONSENT

If the woman is eligible to participate, introduce and explain the EMiNA study, what it is about.

- Ask the participant if they have read the participant information sheet. Cover the main points of the participant information sheet again, particularly those relating to confidentiality
- Emphasise that participation is voluntary and that she does not have to participate. Ensure that you give the participant plenty of time to ask questions. Assure the woman that non consent will not have a bearing on the support she will receive from the Service.

Ask the participant, if they are willing to consent

No consent given

- If the potential participant is unwilling to consent, thank them for their time and make a note of any reason given for non-participation (do not actively ask for this). Give the person the
- £10 gift voucher and reimburse them for their travel expenses (record non-consent in database).
- **Consent given**
- If the woman agrees to participate in the study take her through each paragraph of the consent form, ensuring that she signs both copies. Hand one copy to the participant and keep one for the researcher.
  - Ensure that it is safe for the woman to take the consent form and participant information away with her. If not then offer the option of storing her materials for her at the University.
    - 6) If the participant has consented to take part, conduct the interview.
  - Record non consent in the screening section of the study database.

2.4. INTERVIEW

- If the women consents to participate in the study, and once the relevant paper work has been completed, start with interview.

2.5. AFTER INTERVIEW

- Ask the woman if she has any more questions before you finish the meeting.
- Consent will be re-checked at the end of the interview with the woman, to ensure that the woman is happy for the data collected during the interview to be used for the research. She will have the option to withdraw her consent after the interview has been completed if, on reflection on the interview, she no longer wishes her data to be used for the research.
- Remind her that she can contact you at any time by phone, text or email. Suggest that the woman saves your number in her phone if it is safe to do so.
- Give the woman copies of the participant information sheet, consent form, participant support sheet if it is safe for her to take them away. If she does not feel it would be safe offer to store them for her in a secure filing cabinet at the University.
- Reimburse the woman for her travel expenses if she has had to travel to meet you.
- Give her £10 gift voucher for the interview.

Contact the service following face to face meeting

- Contact the colleague at the service to inform them of meeting completion.

On return to the office

- Complete the relevant sections of the study database
- Download the audio recording
- Store the completed questionnaires separately from the other participant information (consent forms, contact form etc.) Ensure that all information is stored securely in a locked filing cabinet.
- Write "thank you" text and invite them to get in touch again if there are any questions.

3. INTERVIEW WITH PROFESSIONALS

3.1. Before the interview

- The researcher will assemble a recruitment pack consisting of the participant information sheet, the participant support sheet and 2 x consent forms.
- The researcher will obtain a £60 gift voucher to take.
- The researcher will ensure that all equipment is ready and working e.g. digital recorder having sufficient battery life, mobile phone charged etc.
- The researcher will follow the „researcher safety protocol" regarding the „checking-in" system and advance information gathering re venue etc.

3.2. ESTABLISHING INFORMED CONSENT

- Introduce yourself to the professional and thank her for agreeing to see you.
- Introduce and explain the EMiNA study, what it is about.
- Ask the participant if they have read the participant information sheet. Cover the main points of the participant information sheet again, particularly those relating to confidentiality
- Emphasise that participation is voluntary and that the professional does not have to participate. Ensure that you give the participant plenty of time to ask questions.

Ask the participant, if they are willing to consent

No consent given

- If the potential participant is unwilling to consent, thank them for their time and make a note of any reason given for non-participation (do not actively ask for this). Give the person the £60 gift voucher and reimburse them for their travel expenses (record non-consent in database).
- **Consent given**
- If the professional agrees to participate in the study take him/her through each paragraph of the consent form, ensuring that he/she signs both copies. Hand one copy to the participant and keep one for the researcher.
  - Ensure that it is safe for the professional to take the consent form and participant information away with him/her. If not then offer the option of storing his/her materials for her at the University.
  - If the participant has consented to take part, conduct the interview.
  - Record non consent in the screening section of the study database.

3.3. AFTER INTERVIEW

- Ask the professional if he/she has any more questions before you finish the meeting.
- Remind him/her that he/she can contact you at any time by phone, text or email.
- Give the participant copies of the participant information sheet, consent form, and participant support sheet if it is safe for him/her to take them away. If he/she does not feel it would be safe offer to store them for her in a secure filing cabinet at the University.
- Give the professional the £60 gift voucher for the interview.

Contact the service following face to face meeting

- Contact the colleague at the service to inform them of meeting completion.

On return to the office

- Complete the relevant sections of the study database
- Download the audio recording
- Store the completed questionnaires separately from the other participant information (consent forms, contact form etc.) Ensure that all information is stored securely in a locked filing cabinet.
- Write "thank you" e-mail and invite them to get in touch again if there are any questions.

Appendix 9. **Researcher safety protocol**

University of BRISTOL

Appendix 17: SAFETY PROTOCOL FOR EMiNA PARTICIPANTS AND RESEARCHERS

A. RESEARCH PARTICIPANT SAFETY

General points to ensure participant safety

- Never contact a participant without first checking it is safe to do.
- Be aware that participants' movements might be being monitored and choose locations which are safe.
- Remember that participants might not be able to take information away with them.
- Be aware of the limits of confidentiality and inform participants of this limitation.

Specific measures to ensure participant safety

RISK	MEASURES TAKEN TO MINIMISE RISK
Recruitment and consent	
Perpetrator or persons known to perpetrator and/or participant may attempt to obtain information about the participant.	Women will be able to discuss the research project and safe ways of being contacted before deciding to participate. They will be reassured of strict confidentiality and complete anonymity. Under no circumstances will the researcher discuss any information with any other person other than the research supervisors, if need be.
The increased risk of danger to women if perpetrators obtain forms stating consent to participate in a study relating to domestic abuse.	Consent forms will need to be completed before participating in the research. Women will be invited to have copies of consent forms for their own records, if they wish. If a copy is required, options will be discussed with women about how they will be able to maintain a copy safely (e.g. a copy may be kept with a friend).
Telephone contact	
Telephone conversation is overheard by perpetrator or any other person.	Initially women will be asked if it is safe for them to be contacted over the telephone. Various options will be discussed with women who are not able to use their home telephone. They will be asked if they have a mobile telephone or if they are able to gain access to one. The safety of women will take upmost priority. Permission will be sought from [redacted] refuges etc. to allow women who have used their services to gain access to the telephone at the venues.
Telephone conversation is overheard by perpetrator or any other person.	An agreement will be made with each participant on how to manage the situation if the conversation is overheard by any other person. A possible suggestion will be to start discussing about general 'safety in the home', for example to talk about electric socket covers. At the first telephone contact a clear procedure will be discussed with each woman in case she is assaulted. Women will be asked if it will be appropriate for the researcher to call the police. If so they will then be asked to disclose their address.
The telephone call may be recorded on the itemised	Women who phone the researcher will be offered to be called back to save them costs and to minimise the chance of the perpetrator

telephone bill.	identifying the call, especially if it is of long duration.
The perpetrator obtains the recruitment telephone number and wishes to trace it by calling it.	No indication of the research will be given immediately to any caller until the identity of the caller has been established. This will allow for protection of women who may have called earlier but their calls may have been monitored by the perpetrator. If the mobile phone is switched off for any reason the voicemail message will not give any indication that it is a contact number for research related to domestic violence. The message will state to only leave a message and any contact details if it is safe to do so.
Face to face meetings	
Danger of perpetrator interrupting the meeting.	Where possible and convenient, meetings will take place at refuges and community centres instead of the homes of participants. In cases where women request to meet up at their home address, the research will take special precautions to ensure her own and the participants' safety (refer to 'researcher safety' section below) In the event of an emergency, members of staff at the venue will be notified immediately. The researcher will have access to a mobile phone and a screech alarm at all times.
Some women may fear being recognised if surveyed in a public place.	There will be no indication that meetings are being held to investigate domestic violence in case women are seen entering the public place.
The participant may be followed to the location of where the meeting is to be held by the perpetrator.	Participants will be informed on initial contact that they should not put themselves at any risk by participating in the study. Participants will be advised only to make contact when they are certain there is no other person present who may overhear the conversation. Meetings will take place at venues where members of staff will be nearby but not in the meeting rooms. The researcher will carry a mobile that will be on at all times. The researcher will also be in possession of a screech alarm.
Research materials	
Another person looking at the material or taking it, losing the material.	All research material is highly confidential. The research material will be kept in a locked briefcase when travelling to locations. If the material is kept at the researcher's home or at the university it will be kept in a locked filing cabinet in a secure room.

Child Protection Protocol

- All participants will be told of the limits of confidentiality in relation to child protection issues.
- Participants will not be specifically asked about issues of child protection.
- When a child protection issue arises, the researcher should try to discuss the issue further with the participant and establish whether other professionals are involved and if necessary get permission to contact those individuals.
- When working closely with a third party organisation, this may involve discussing concerns with the key worker.
- It is good practice for the researcher to tell a participant if they intend to break confidentiality.
- The researcher should always discuss the incident with other team members before deciding whether to report to social services/the police.
- If the researcher has concerns about a child's welfare and is not satisfied that other professionals are aware of and dealing with the issue, they will report it to the duty officer of the relevant Social Services office.

B. RESEARCHER SAFETY

General points to ensure researcher safety

- Researchers will not give out any personal information, including personal mobile numbers to potential participants. This includes texting.
- Researchers will ensure that colleagues know about their whereabouts when conducting fieldwork.
- Researchers will always carry a mobile phone and a screech alarm. Mobile phones should be regularly recharged and emergency contact numbers set to speed dial.
- When conducting research within the premises of a third party, researchers will adhere by the safety protocols of that organisation.
- When conducting research or at 3rd party premises, researchers will follow the procedures for 'lone working' laid down in the Department's code of practice. This includes making telephone contact with a designated work colleague or supervisor at a set time after the meeting is due to finish in order to ensure that the researcher has left the premises and is safe.
- All researchers employed on the EMiNA study will have the necessary skills and experience to conduct research around violence issues.
- The research team will meet regularly in order to address any emotional issues which have arisen.
- Work based counselling from team colleagues will be available if required.

Specific measures to ensure researcher safety

RISK	MEASURES TAKEN TO MINIMISE RISK
Disclosure of researcher's identity	Researchers will agree a pseudonym with participants to be used in conversations instead of their real name.
Abusive and threatening calls to researcher	The telephone numbers displayed on study documents will be for research purposes only. The researcher's personal mobile number or home landline number will not be given out to any person under any circumstances.
Threats to researcher during fieldwork at participants' homes or at 3rd party premises.	Supervisors or work colleagues will be notified of times and locations of every appointment and approximately how long each interview will take. A code phrase will be agreed between the researcher and their designated contact to signal if they feel at risk and require support without alerting the perpetrator. In case of using 3rd party premises, reception staff at each venue will be notified by the researcher of their arrival and departure times, as well as the room of where meetings will take place and will be instructed to keep this information confidential.

C. EMOTIONAL WELLBEING

This kind of work is emotionally demanding, so the following steps will be taken to ensure that the researcher is adequately supported:

- Where possible, the researcher will limit herself to one participant interview per day.
- The researcher will consider after each interview whether a time of debrief is necessary with her supervisors (Professor Gene Feder and Dr Ali Heawood), Dr Maggie Evans and/or Sue Penna (a counsellor with expertise in the field of domestic violence) by phone or in person. Where possible, this should happen within 48 hours of the visit.
- In regular supervision meetings, the researcher will have the opportunity to discuss any emotional aspects of the work, addressing any particular issues that have arisen.
- In quarterly debriefing sessions with Sue Penna (a counsellor with expertise in the field of domestic violence), the researcher will have further opportunity to discuss any emotional aspects of the work, addressing any particular issues that have arisen.
- If after debriefing, the researcher is still in need of support, she can access the University of Bristol staff counselling service (http://www.bris.ac.uk/staffcounselling/) who can usually arrange appointments within a week.

The potential for impact on the emotional wellbeing of those involved in the transcription of the interviews is noted, particularly due to the immersive nature of the work. They will therefore be offered support, the opportunity to debrief and access to counselling.

EMiNA

D. Out of office research interviews: contact details and call-in form

1 copy to designated contact person
1 copy with researcher
Leave the name, address and telephone number of the interviewee (in a sealed envelope to preserve confidentiality, but to provide access to the details should the need arise) with the designated contact person.

Researcher's name	Nadia Khelaifat
Day and date of interview	
Location of interview inc. address	
Telephone number of interview location	
Estimated start time of interview	
Estimated finish time of interview	
Researcher's mode of transport	
Researcher's mobile telephone number	XXXX XXXXXXX

Call-in information:

Name and phone number of designated contact person	

BOX A	
Time that researcher will call designated contact person after the interview	

BOX B	
Designated contact person sign here to show that researcher is safe	

BOX C	
Time that designated contact person should call researcher if BOX B not completed	

BOX D

Time that designated contact person should call police if BOX B not completed

[1]

[1] EMiNA, Centre for Academic Primary Care, University of Bristol, *Safety protocol * v1_5.11.2012

Instructions to designated contact person

1) If researcher does not call to report safe, then at time in **BOX C,** call the researcher on their mobile phone number.

2) If no response, call the interview location and ask to speak to the researcher.

3) If no response, try calling the researcher again on their mobile phone number.

4) If no response, at time in **BOX D**, stay calm and do the following: Call 999

   Explain the situation calmly to the police

   Give the police:

   1. YOUR NAME
   2. YOUR PHONE NUMBER
   3. RESEARCHER'S NAME
   4. RESEARCHER'S MOBILE PHONE NUMBER
   5. LOCATION AND ADDRESS OF INTERVIEW
   6. THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE RESEARCH PARTICIPANT (open sealed envelope)
   7. EXPECTED TIME OF INTERVIEW ENDING

   Ask the police to visit the interview location to check that the researcher is alright.

Appendix 10. **Participant cover letter to women**

From:

Nadia Khelaifat

University of BRISTOL

Centre for Academic Primary Care

NIHR School for Primary Care Research
School of Social and Community Medicine

University of Bristol

EMiNA: Evaluation of Migrant women's Needs regarding Domestic Violence Abuse

Dear Service User

We are researchers at the University of Bristol. We are writing to you about a study that we are carrying out looking at the needs of migrant women who have experienced domestic abuse. In particular, we are interested in identifying how migrant women experiencing domestic violence are currently supported by healthcare and other agencies. We are writing to you to ask whether you would be willing to take part in this study.

If you are happy to help us with our research, this will involve taking part in an (approximately 60 minute) face-to-face interview with a University researcher in the premises [redacted] or other safe community or university setting in a private location. The interview will ask you about your experiences when seeking and receiving help regarding domestic abuse. The information you provide in the interview will be confidential. Only the professional who told you about this study and the researchers at the University will know that you are taking part in the study. Only the researchers will know what you have said during the interview.

We enclose an information sheet that gives you more details. If you are happy to take part, please get in contact with your support worker to fill out the 'willingness to be contacted' form. This tells us whether you are happy to be contacted and your telephone number so a researcher from the University will telephone you to talk to you about the study and arrange a suitable date/time for your interview. Alternatively, if you have taken this information home to read and you are interested in taking part, please contact Nadia Khelaifat on ☎ .

If you would like further information, please contact Nadia Khelaifat who will be glad to answer any questions you have. Your participation is voluntary. But we do hope that you will feel able to help us with this study, as we believe it will help us to develop appropriate interventions to help women in your situation. Thank you for reading this.

Yours sincerely
Nadia Khelaifat
Research Associate

Appendix 11. **Participant information sheet for women**

What are the possible difficulties of taking part?

If you take part in the study, you will need to give about one hour of your time for the interview. Because of the topic of the interview, you may find it difficult or upsetting to talk about some of your experiences. The researcher, Nadia Khelaifat, will listen to you sensitively and you can decide what you want to share. Also, you will be free not to answer any questions if you prefer not to.

Why is it important to know about your experiences of domestic abuse and how health professionals have helped you?

Domestic violence is one of the greatest health risks for all women and children. Yet it might have been more difficult for you to seek and find help. So in this study, we want to find out what kinds of support you have received from healthcare and other agencies.

The results will be used to find out the most appropriate ways of supporting women in your situation. We particularly want to know how doctors (GPs) and other health care professionals might best be able to help you.

EMiNA, Centre for Academic Primary Care, University of Bristol, *Participant information sheet for migrant women * v3_7.12.2012_Appendix 8

What do I do now?

If you are happy for a University Researcher (Nadia Khelaifat) to contact you about this study, please tell the professional who gave you this information. Then complete the 'willingness to be contacted details' form with your support worker. Your support worker will then let Nadia Khelaifat know. You can also telephone Nadia Khelaifat directly if you are interested in taking part. If she cannot take your call, please leave a message. Nadia Khelaifat will then telephone you to see if you are happy to take part in the study.

Who is organising and funding the study?

The study is being organised by researchers at the University of Bristol – see our contact details below. It is funded by the Avon Primary Care Research Collaborative, NIHR Research Capability Funding.

Who has reviewed the study?

The study has been assessed by the Faculty of Medicine and Dentistry Committee for Ethics and the National Health Services Research & Development to make sure that your safety, rights, wellbeing and dignity are being protected.

What if there is a problem?

If you have concerns about any aspect of the study, please contact the researcher and she will do her best to answer your questions. If you do not want to speak to the researcher, you can contact Dr Emma Williamson who acts as an independent contact point by telephone or by e-mail: . If you wish to make a complaint, you can contact Dr Ali Heawood – telephone or e-mail .

Study Contact:

INFORMATION FOR PARTICIPANTS

EMiNA: Evaluation of Migrant Women's Needs regarding Domestic Violence Abuse

University of BRISTOL

Invitation to take part in a research study

We are inviting you to take part in a research study. At the University of Bristol, we are doing some research on abused migrant women's needs regarding support from healthcare and other agencies. Please consider whether you would like to take part in this study. Before you decide whether to take part, it is important for you to read the following information carefully and talk about it with someone you trust, for example, your support worker. Please ask if anything is not clear or if you would like more information before you decide. The researcher, Nadia Khelaifat, is happy to give you more information about it.

Why am I being invited to take part?

We are inviting you if because you are a migrant woman who has experienced domestic violence. We want to find out your views about service provision.

What are the possible benefits of taking part?

Your experiences could help health care professionals to have better understanding of what migrant woman need when experiencing domestic violence.

The results of this study are intended to improve health care responses.

What will I need to do if I take part?

Thank you for taking time to read this information leaflet, and for considering part in this research.

If you're happy to take part, you will be invited to take part in one interview with a researcher from the University.

- The interviews will take place in the premises of, for instance, [redacted] or other safe settings and will last about one hour.
- The interview will be arranged as soon as possible.
- The researcher will arrange the interview on dates and times to suit you. The interviews will be recorded using a digital voice recorder. The interview recordings will be copied to a secure university computer. They will be typed-up by a secretary.
- For the interview you will be given a £10 gift voucher to say "thank you" for taking part.

If I take part will it be kept confidential?

Anything you say in the interviews will be treated in strictest confidence. Only the research team at the University will know that you have taken part in the study. Your name will not be used when writing up the results of the study. The only exception to this confidentiality will be if you disclose information which suggests a serious risk of safety to any person (including yourself). The researcher has a legal obligation to share information with other agencies if she thinks that the safety of a child is at risk. If this happens she would discuss it with you first.

What happens when the study ends?

We will write up the results as a report for the Avon Primary Care Research Collaborative who have funded this study. We will also publish the results in journals that will be read by health professionals and researchers. You will not be identified in any of these reports. We are happy to give you a copy of the results.

Do I have to take part?

No, it is voluntary. You do not have to take part, even if your support worker asks you to. You are free to withdraw at any time without anyone minding. We are happy to answer any questions and give you more information.

Appendix 12. **Participant consent form for women**

Appendix 11: Consent and request for summary form for migrant women

University of BRISTOL

EMiNA

Study ID

Participant Consent Form

We need to ask you to sign to show that you understand what taking part in this study will mean and that you are willing to do so.

Please read this consent form carefully and put your initials in the boxes next to the items you agree with and give your consent to.

Please initial boxes, example:

NF	✓
Correct	Incorrect

Please initial box

1. I confirm that I have read (or that the information sheet has been translated and explained verbally to me) and understand the information sheet for the above study, and that I have had chance to consider the information and to ask any questions. ☐
2. I understand that taking part in the research interview is voluntary, that I can change my mind about it, and that I am free to leave at any time. ☐
3. I understand that I can ask for the research interview to be stopped, or to withdraw from the research, without having to give a reason. ☐
4. I understand that the research interview will be recorded digitally and that the recording will be stored on a secure computer at the University of Bristol. ☐
5. I understand that the typed up report of the interview will be anonymised and that I will not be identifiable in any written reports, articles or presentations resulting from the research. ☐
6. I understand that my personal details (such as my name and address) will be treated with strict confidence, will be stored securely at the University of Bristol, and will not be passed on to anyone outside of the study team. ☐
7. I understand that the information I share will be kept confidential and I agree to the University of Bristol recording and processing information about me for the research ☐
8. I understand that if the researcher has serious concerns about my safety or that of any children I may mention that she may need to share this concern with an appropriate agency, which she will discuss with me first. ☐
9. I understand that at the end of the study, my interview data will be stored for 10 years in a secure facility at the University of Bristol. ☐
10. I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

When completed, 1 copy for researcher, 1 copy for participant

EMiNA, Centre of Academic Primary Care, University of Bristol*Participant Consent form*Version 3*7/12/12

Appendix 11: Consent and request for summary form for migrant women

My wishes for involvement in this study and other related domestic violence research studies:

	Please initial box	
1. I would like to receive a summary of the research findings once the study has finished.	Yes	No
2. I agree that you may contact me about other research studies which look at interventions regarding domestic violence. I understand that I am under no obligation to take part in any future research and would be given full information before making a decision.	Yes	No

Appendix 13. **Willingness to be contacted form**

University of BRISTOL

Appendix

Permission for Researcher Contact Form

I agree that the female researcher at the University of Bristol carrying out the EMiNA study can contact me. This will enable her to explain the study in more detail so that I can then decide whether or not to take part.

Participant

PRINT NAME: _____

Safe telephone number(s): _____

Safe e-mail address: _____

SIGNATURE: _____ DATE: _____

Appendix 14. **Cover letter to other professionals**

From:

Nadia Khelaifat

University of BRISTOL

Centre for Academic Primary Care

NIHR School for Primary Care Research
School of Social and Community Medicine

University of Bristol

Canynge Hall

13 February 2013

Dear [insert name]

EMiNA: Evaluation of Migrant Women's Needs regarding Domestic Abuse

We are members of a research team at the University of Bristol. We are writing to you about a research study that we are conducting, funded by the Avon Primary Care Research Collaborative, NIHR Research Capability Funding. In this study we are looking at the support needs of migrant women who have experienced domestic abuse, any gaps in that support and the potential role of primary care.

We are hoping to recruit professionals from within primary care and third sector domestic abuse agencies in [redacted] to help us with this study. We are writing to you to ask whether you would be willing to consider taking part in this study. If you participate, this will involve taking part in an (30-60 minute) interview with a University researcher, either face-to-face or by telephone. We will ask you how you currently support migrant women affected by domestic violence, what the gaps in support are and your own needs regarding providing appropriate help for these women.
The researcher (Nadia Khelaifat) will contact you by telephone over the next two weeks, to see if you are willing to help us. If you would like further information, please contact Nadia on ☎ ..... and she will be glad to answer any questions you have. The study has been approved by the University of Bristol Faculty of Medicine and Dentistry Research Ethics Committee. We can give you a copy of the approval letter should you require it for your records.

Thank you for reading this.
Yours sincerely

Nadia Khelaifat
Research Associate

Appendix 15. **Participant information sheet other professionals**

If I take part will it be kept confidential?

In order to ensure that professionals' identities remain anonymous, anything you say in the interview with the researcher (Nadia Khelaifat) will be treated in strictest confidence. Only the research team at the University will know that you have taken part in the study. We will not use your name when we write up the results of the study.

Why do we want to interview you?

The study hopes to shed light into the needs of a) abused migrant women and b) professionals supporting these women. This will help to identify what sort of intervention, or refinement of an existing intervention (e.g. the IRIS Programme - Identification and Referral to Improve Safety) might be appropriate to better support migrant women and professionals within primary care.

Funding, Ethics and Contacts

Who is organising and funding the study?

The study is being organised by researchers at the University of Bristol – see our contact details below. The study is funded by the Avon Primary Care Research Collaborative, NIHR Research Capability Funding.

Who has reviewed the study?

The study has been reviewed by the University of Bristol, Faculty of Medicine and Dentistry, Research Ethics Committee.

What if there is a problem?

If you have concerns about any aspect of the study, please contact the researcher and she will do her best to answer your questions. If you do not want to speak to her, you can get in touch with Dr Emma Williamson who acts as an independent contact point by telephone or by e-mail

If you wish to make a complaint, you can contact Dr Ali Heawood – telephone

Study Contact:

INFORMATION FOR PROFESSIONALS

EMiNA: Evaluation of Migrant Women's Needs regarding Domestic Abuse

University of BRISTOL

EMiNA, Centre for Academic Primary Care, University of Bristol, *Participant information sheet for professionals * v2_7.12.2012_Appendix 6

Invitation to take part in a research study

We are a team of researchers at the University of Bristol. We are conducting a research study looking at the support needs of migrant women experiencing domestic abuse and the potential role of primary care.

We are interested in the views of professionals from a range of settings (within and outside of primary care) regarding how migrant women experiencing domestic abuse are currently supported by healthcare and other agencies. In particular, we are interested in identifying any gaps in current support for migrant women and how these might be addressed, from both the migrant woman's and the professional's perspective.

We are inviting professionals from a range of settings [redacted] (primary care and third sector domestic abuse agencies) to take part in an interview.

Would you be willing to consider taking part in this study?

If you want to participate, this will involve

We are inviting professionals to take part in a 30-60 minute interview with a University researcher, either face-to-face or by telephone. The interview will explore views about the needs of abused migrant women and how they might best be supported by primary care. It will also explore the needs of professionals when dealing with abused migrant women.

Will my practice/organisation be reimbursed for my contribution to the study?

Yes – based on the general hourly rates we will be able to reimburse each professional interview to cover the time involved.

Why is it important to know about migrant women's support needs regarding domestic abuse and the role of primary care?

Domestic abuse is one of the greatest health risks for women and children. It is common yet hidden within general practice and remains under-researched. Certain factors such as their specific immigration status and lack of language skills seem to make migrant women more likely to experience domestic abuse and also appear to be obstacles to accessing support. This makes the uncovering of domestic violence as experienced by migrant women challenging, for primary care and other professionals.

EMiNA, Centre for Academic Primary Care, University of Bristol, *Participant information sheet for professionals * v2_7.12.2012_Appendix 6

Appendix 16. **Participant consent form for professionals**

University of BRISTOL

Appendix 15: Consent form and request for summary form

Participant's ID code:

CONSENT FORM FOR PROFESSIONALS

Title of Project:	**EMiNA**
Study contacts:	Nadia Khelaifat
Contact details:	University of Bristol, Centre for Academic Primary Care, School of Social and Community Medicine, Canynge Hall, 39 Whatley Road, Bristol, BS8 2PS. Tel: .

Please initial box

1. I confirm that I have read and understand the information sheet for this study and have had the opportunity to ask questions. ☐☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐☐
3. I understand that the interview will be recorded on a digital voice recorder and the recording will be stored on a secure computer at the University. ☐☐
4. I understand that the interview transcript will be strictly confidential and that I will be anonymous in any written reports from the research. ☐☐
5. I understand that my personal details (e.g. name, address, date of birth) will be strictly confidential, will be stored securely at the University and will not be passed on to anyone within or outside the University. ☐☐
6. I agree to take part in the above study by taking part in an interview. ☐☐

Name of Participant	Date	Signature
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher

University of BRISTOL

Appendix 15: Consent form and request for summary form

My wishes for involvement in this study and other related domestic violence research studies:

	Please initial box	
1. I would like to receive a summary of the research findings once the study has finished.	Yes	No
2. I agree that you may contact me about other research studies which look at interventions regarding domestic violence. I understand that I am under no obligation to take part in any future research and would be given full information before making a decision.	Yes	No

Appendix 17. **Participant information sheet for professionals**

If I take part will it be kept confidential?

In order to ensure that professionals' identities remain anonymous, anything you say in the interview with the researcher (Nadia Khelaifat) will be treated in strictest confidence. Only the research team at the University will know that you have taken part in the study. We will not use your name when we write up the results of the study.

Why do we want to interview you?

The study hopes to shed light into the needs of a) abused migrant women and b) professionals supporting these women. This will help to identify what sort of intervention, or refinement of an existing intervention (e.g. the IRIS Programme - Identification and Referral to Improve Safety) might be appropriate to better support migrant women and professionals within primary care.

Funding, Ethics and Contacts

Who is organising and funding the study?

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Who has reviewed the study?

The study has been reviewed by the University of Bristol, Faculty of Medicine and Dentistry, Research Ethics Committee.

What if there is a problem?

If you have concerns about any aspect of the study, please contact the researcher and she will do her best to answer your questions. If you do not want to speak to her, you can get in touch with Dr Emma Williamson who acts as an independent contact point by telephone or by e-mail .

If you wish to make a complaint, you can contact Dr Ali Heawood – telephone or e-mail .

Study Contact:

INFORMATION FOR PROFESSIONALS

EMiNA: Evaluation of Migrant Women's Needs regarding Domestic Abuse

University of BRISTOL

Invitation to take part in a research study

We are a team of researchers at the University of Bristol. We are conducting a research study looking at the support needs of migrant women experiencing domestic abuse and the potential role of primary care.

We are interested in the views of professionals from a range of settings (within and outside of primary care) regarding how migrant women experiencing domestic abuse are currently supported by healthcare and other agencies. In particular, we are interested in identifying any gaps in current support for migrant women and how these might be addressed, from both the migrant woman's and the professional's perspective.

We are inviting professionals from a range of settings [redacted] (primary care and third sector domestic abuse agencies) to take part in an interview.

Would you be willing to consider taking part in this study?

If you want to participate, this will involve

We are inviting professionals to take part in a 30-60 minute interview with a University researcher, either face-to-face or by telephone. The interview will explore views about the needs of abused migrant women and how they might best be supported by primary care. It will also explore the needs of professionals when dealing with abused migrant women.

Will my practice/organisation be reimbursed for my contribution to the study?

Yes – we will pay £60 for each professional interview to cover the time involved.

Why is it important to know about migrant women's support needs regarding domestic abuse and the role of primary care?

Domestic abuse is one of the greatest health risks for women and children. It is common yet hidden within general practice and remains under-researched. Certain factors such as their specific immigration status and lack of language skills seem to make migrant women more likely to experience domestic abuse and also appear to be obstacles to accessing support. This makes the uncovering of domestic violence as experienced by migrant women challenging, for primary care and other professionals.

Appendix 18. **Cover letter to healthcare professionals**

From:

Nadia Khelaifat

Tel:

University of BRISTOL

Centre for Academic Primary Care

NIHR School for Primary Care Research
School of Social and Community Medicine

University of Bristol

Canynge Hall

Professionals' name and address

Date:

Dear (professional's name)

EMiNA: Evaluation of Migrant women's Needs regarding Domestic Abuse

We are members of a research team at the University of Bristol. We are writing to you about a research study that we are conducting, funded by the Avon Primary Care Research Collaborative, NIHR Research Capability Funding. In this study we are looking at the support needs of migrant women who have experienced domestic abuse, any gaps in that support and the potential role of primary care.

We are hoping to recruit professionals from within primary care and third sector domestic abuse agencies in [redacted] to help us with this study. We are writing to you to ask whether you would be willing to consider taking part in this study. If you participate, this will involve taking part in an (30-60 minute) interview with a University researcher, either face-to-face or by telephone. We will ask you how you currently support migrant women affected by domestic violence, what the gaps in support are and your own needs regarding providing appropriate help for these women.

The researcher (Nadia Khelaifat) will contact you by telephone over the next two weeks, to see if you are willing to help us. If you would like further information, please contact Nadia on ☎ …… and she will be glad to answer any questions you have. The study has been approved by the University of Bristol Faculty of Medicine and Dentistry Research Ethics Committee. We can give you a copy of the approval letter should you require it for your records.

Thank you for reading this.

Yours sincerely

Nadia Khelaifat

Research Associate

Appendix 19. **Confidentiality protocol**

University of BRISTOL

EMiNA

Purpose

Researchers have a responsibility to uphold confidentiality regarding the involvement of, and the information shared by, participants during the research process. However, there are some rare circumstances when the researcher may have to break the agreement of confidentiality with the participant, for example when legal mandates need to take precedence. Along with health professionals, researchers are required by law to declare information that concerns terrorism, drug trafficking offences and safeguarding issues. Safeguarding includes situations of serious risk to the safety of any person (including the participant), and particularly children and vulnerable adults.

This protocol is concerned with the procedures involved with participant confidentiality.

Communicating Confidentiality

The participant information sheet and the participant consent form both contain explanations regarding the limits of confidentiality and the researcher's obligations to disclose information of an unlawful nature. The participant will receive the afore mentioned information at least 48 hours prior to the interview and the researcher will check that the participant has both read the information, and feels that they understand it, prior to the start of the interview. The researcher will reiterate some of the messages in the participant information, including the issues around, and limits of, confidentiality, and the participant will have opportunities to ask any questions they may have.

Breaking Confidentiality

Should the situation arise where the researcher needs to break the confidentiality of the participant, the following steps will be adhered to:

1) If appropriate the researcher will indicate to the participant that part of the information they have shared has given them cause for concern, that they feel they have an obligation to pass on the information, and that they will need to speak to their supervisors (Professor Gene Feder and Dr Ali Heawood) about how to proceed. Inappropriate circumstances for sharing this information with the participant would be if the researcher felt it would compromise their own safety or that of others to do so.
2) The researcher will discuss the issue with her supervisors as soon as possible after the incident, flagging up that it is a matter of some urgency (the researcher has personal contact numbers for her supervisors in addition to work contact details, so that she can get in touch quickly should the need arise).
3) The researcher's supervisors will help the researcher to make a decision about whether confidentiality needs to be broken and to decide who to inform regarding the information shared.
4) If at all possible, and if appropriate, the researcher will attempt to contact the participant to let them know that it is necessary to break their confidence, and to let them know with whom the information will be shared. Inappropriate circumstances for sharing this information with the participant would be if the researcher felt it would compromise their own safety or that of others to do so.
5) The researcher will contact the relevant organisation, e.g. police, social services, and share the information of concern.
6) The researcher will document the incident.

Appendix 20. **Topic guide for women**

EMiNA
Evaluation of Migrant women's Needs regarding Domestic Abuse

Topic guide for migrant women

Objectives

- To explore the needs of abused migrant women regarding communication with health care professionals
- To explore their experiences of health care professionals' (and other agencies') responses
- To explore barriers and facilitators to accessing health care services and agencies

Introduction

- introduction of study and own person
- check for eligibility
    a. safe from perpetrator?
- check understanding of participant information sheet and consent form
- confidentiality
- give opportunity for questions
- signing of consent form (x2)

1 Present circumstances

- age, DOB
- family status
- children (age & gender? & number)
- religion
- summary of current situation (work etc.)
- current living situation
- sources and level of income

2 Life and migration history

Details may help to understand the relationship between DV and migration

- country of origin
- native language
- school education and highest qualification
- immigration status
- when got married?
- language spoken at home

- **Coming to Britain**

    - when arrival in Britain

- reason for coming to Britain
- total duration of stay in Britain
- knowledge of English language beforehand
- experiences and feelings regarding migration
- how well prepared?
- important family members/friends here?
- experience living in Britain +/- (discrimination, difference in culture?)
- changes
- feeling "British"/integrated?

3 DV

- **Experience**
  - experience of DV, what happened?
  - definition or meaning for them
  - when did it start (e.g. before, during, after migration?)
    - events surrounding beginning?
  - perpetrators (e.g. family-in-law)
    - forced marriage

- **Feelings**
  - how felt
  - how felt others saw them

- **Effect**
  - changes in life
  - impact on other areas (e.g. isolation, exclusion from community, children)
  - impact on physical/mental health (injuries)
    - making the link (awareness)?
- **Coping strategies**
  - how managed during that time
  - personal resources (e.g. religion/spirituality)
  - what made them seek help? (e.g. children)

4 Sources of help

Informal sources of help

- who helped them
- experience +/-
- reaction of family/friends to disclosure or imagined reaction?+/-
- communication (feeling understood)
- what role they played in life
- whether remained in contact with anyone from home/family background/friends
- how made difference

Health care sector

- experience
- which services used (emergency vs GP)

- who did they see (doctor, nurse, health visitor, midwife)
- why those health services (why not others – injuries?)
- why did they come? (Expectation?)
- communication (non-verbal communication)
- what did they talk about? (health problems)
- feeling understood? Rapport?
- misunderstandings
  - problems when talking to HCPs?
- how was confidentiality explained?
- barriers here? (prompts e.g. language/ interpreting, distance, family members, sensitivity, feelings, time constraints etc.)
- screened for DV/asked about DV
  - manner of asking
  - response (denial/disclosure)
  - response HCP appropriate?
  - medicalizing DV?
  - pressure? pressing for action? (e.g police involvement)
  - satisfaction with help?
  - Referral?
- DV health legitimate issue?

5 Barriers to accessing health services/services

- not knowing about services/being familiar with these, not being familiar where to seek help
- language
  - communication
  - (mis-)understandings
  - lack of interpreters
- concerns about confidentiality
  - trust and rapport issues between woman and professional, non-verbal communication
- emotions (e.g. fear, shame, guilt, embarrassment, distrust)
- being accompanied by family members
  - isolation
  - threats to keep quiet
- denial of abuse
- cultural values (family matter, marriage is holy)
- immigration status
  - fear of deportation/ losing custody of children
  - concerns about police involvement
  - distrust
- perceived discrimination
- belief that abuse is not a medical problem or valid problem to be discussed with professionals
- why do other women do not seek help?

6 Views about and expectations regarding the health professional's role in caring for migrant women affected by domestic violence

- do they see primary care professionals as having a role in supporting them or facilitating access to appropriate support?
- what would they like them to know and do?
- opinion regarding screening for DV?
- in which manner should it be addressed?
- how should GPs/HCPS treat migrant women affected by DV?

- in how far they think it would be good if the HCPS were from own community?
- wishes regarding support?
- to what extent think HCPs can help migrant women with DV?
- right professionals to be doing this?
- who else (if anyone) can help?
- to what extent are confident that HCP will be able to help them?

Interpreting

a. interpreting necessary
    i. family member or "professional" used
    ii. issues regarding confidentiality explained
    iii. own feelings about confidentiality
    iv. waiting time
    v. communication change (focus on interpreter?)
b. how made difference

❖ **Support received from third sector agencies**

- hear about services
- what information about accessing services (leaflets vs word of mouth)
- experiences in general?+/-
- what kind of help did/do they receive?
- how sensitive to needs?
- understood situation?
- appropriate responses? (discrimination)
- gaps in support?

Any other issues?

Closure of interview

- briefly look through question sheet to check covered all questions (quick check, if missed, return to questioning or ask expand on previous answer)
- info: end of interview, ask anything else they feel they'd like to say or add?
- ask whether any questions that were of particular interest to them (If so, which? and in what ways?)
- ask the participant if there were any questions that were confusing or difficult to answer? (if so, which? and in what ways?)
- check interview experience and how they are feeling
- withdraw consent?
- thanks (turn off the digital recorder)
- give voucher
- offer the participant the participant support sheet

Appendix 21. **Topic guide for healthcare professionals**

EMiNA (Evaluation of Migrant women's Needs regarding Domestic Abuse)

Interview topic guide for health care professionals (HCPs)

Objectives

- To explore HCPs' experiences of dealing with abused migrant patients
- To explore HCPs' experiences and awareness of the specific situations encountered by migrant women and their own difficulties dealing with them (barriers/differences)
- To explore their training needs to deal with abused migrant women

Introduction

- introduction of study and own person
- check understanding of participant information sheet and consent form
- confidentiality
- give opportunity for questions
- signing of consent form (x2)

1 Participant's background

- Profession, how many years in practice
- age
- own history of migration?
- interests (e.g. interest/qualification in DV)

2 Relationship with diverse migrant patients in general

- experience dealing with migrant/ethnic minority patients
- ways of establishing good rapport
- general barriers encountered when dealing with these patients?
- how overcome barriers?
- knowledge about patients (e.g. voluntary vs forced migration)?
- ways of asking about health (using non-medical/non-psychological terms)?
- health (and illness) communication: mutual understanding?
- feeling of getting to the root of their problems/situation?

3 Experiences and views of consultations with abused women

- general experiences in dealing with female patients affected by domestic violence?
  - ⇨ if so, how do they go about identifying female patients whom they suspect of having experienced domestic violence?
- difficulties when identifying abused women?
- nature of consultations (e.g. topics discussed),
- kind of communication: to what extent open?

- what is the most important thing to say or do in responding to patients whom they suspect might be victims of domestic violence?

4 Views and experiences of dealing with abused migrant women

- experiences with migrant patients affected by DV (or where they had strong suspicions)?
- experiences with women whom they suspected to be DV victims, but chose not to directly identify them (examples and reasons)?
- how DV might differ for migrant women (e.g. knowledge regarding multiple perpetrators)? Additional and/or different obstacles and barriers for them (e.g. language, exclusion from community, immigrations status)?
- what are the challenges they encounter in providing help for abused women and for migrant women in particular?
- what are the (moral) dilemmas they may encounter dealing with abused migrant women (immigration status; also feelings of frustration and helplessness, beliefs: DV normal in their culture; stereotypes)?
- rewards or gratification from working with DV migrant patients?
  - how would they describe abused migrant women's (mental) health?
    - what diagnoses?
      - acceptability of diagnosis? (e.g. stigma)
      - how they explain it?
      - prescription of medication (what medication)?
      - Understanding and compliance with medical regimen?
      - Discussion of other treatment (e.g. counselling) and if so what?
  - **Views of the migrant women's expectations of the consultation**
    - abused migrant woman's expectations from consultation/ patient-doctor-relationship? (satisfaction, expectation to receive medication, preference for another form (e.g. counselling?)
  - provision of intervention (without perhaps directly identifying the patient as a victim of DV)?
  - what did they suggest or say to try to help?
    - referral to DV agency?

5 View of HCPs' role and needs in caring for migrant women with histories of DV

- to what extent do they think HCPs can help migrant women with DV?
- are HCPs the right professionals to be doing this?
- who else (if anyone) can help?
- to what extent do they feel they can help migrant women?
- what help would they require in terms of training in order to help abused migrant women more appropriately?
- suggestions for improvements of existing IRIS training?

6. Views and experiences of working with interpreters

- experience of involving interpreters in consultations with abused migrant women?
- whom did they use?
  - response to family members offers to interpret when DV suspicion?
- procedure of involving an interpreter (re feasibility, time, booking, costs etc)?
- impact of involving an interpreter on relationship with woman?
- how was confidentiality explained to woman and interpreter?

- own experience as interpreter (+/-)?

- **Any other issues**

Closure of interview

- briefly look through question sheet to check covered all questions (quick check, if missed, return to questioning or ask expand on previous answer)
- info: end of interview, ask anything else they feel they'd like to say or add?
- ask whether any questions that were of particular interest to them (if so, which? and in what ways?)
- ask the participant if there were any questions that were confusing or difficult to answer? (if so, which? and in what ways?)
- check interview experience and how they are feeling
- withdraw consent?
- thanks (turn off the digital recorder)

Appendix 22. **Topic guides for other professionals**

EMiNA (Evaluation of Migrant women's Needs regarding Domestic Violence Abuse)

Interview topic guide for professionals

Objectives

- To explore professionals' experiences regarding dealing with abused migrant clients
- To explore professionals' experiences and awareness of the specific situations encountered by migrant women and their own difficulties dealing with them (barriers/differences)
- To get second-hand insights of abused migrant women's experiences in the health care sector
- To explore their views on HCP's training needs regarding abused migrant women

Introduction

- introduction of study and own person
- check understanding of participant information sheet and consent form
- confidentiality
- give opportunity for questions
- signing of consent form (x2)

2 Participant's background

- profession?
- work place
- fulltime/ part time
- age
- family status?
- children (age & gender & number)??
- religion
- own history of migration?
    - how long living in UK?
    - native language
- *lived abroad?*
- interests (e.g. interest/qualification in DV)
- availability of DV services within practice
- previous DV training?

6 Experiences and views of abused women

- general experiences in dealing with female clients affected by domestic violence?
- nature of consultations (e.g. topics discussed),
- kind of communication: to what extent open?
- what is the most important thing to say or do in responding to clients whom they suspect might be victims of domestic violence?

7 Views and experiences of dealing with abused migrant women

- experiences with migrant clients affected by DV (or where they had strong suspicions)?
- experiences with women whom they suspected to be DV victims, but chose not to directly identify them (examples and reasons)?
- how DV might differ for migrant women (e.g. knowledge regarding multiple perpetrators)? Additional and/or different obstacles and barriers for them (e.g. language, exclusion from community, immigrations status)?
- what are the challenges they encounter in providing help for abused women and for migrant women in particular?
- what are the (moral) dilemmas they may encounter dealing with abused migrant women (immigration status; also feelings of frustration and helplessness, beliefs: DV normal in their culture; stereotypes)?
- rewards or gratification from working with DV migrant clients?
- migrant women's experiences regarding help within the health care sector?
    - where did they go?
    - satisfaction?
    - how would they describe abused migrant women's (mental) health?
        - what diagnoses have they received?
            - acceptability of diagnosis? (e.g. stigma)
            - how was this explained to them?
            - prescription of medication (what medication)?
            - understanding and compliance with medical regimen?
            - discussion of other treatment (e.g. counselling) and if so what?
    - **Views of the migrant women's expectations of** patient-doctor-relationship? (expectation to receive medication? Preference for another form (e.g. counselling?)

INTERVENTION

- What did they suggest or say to try to help?
    - Referral to DV agency?

3.1 Views and experiences of working with interpreters

- experience of involving interpreters in consultations with abused migrant women?
- whom did they use?
    - response to family members offers to interpret when DV suspicion?
- procedure of involving an interpreter (re feasibility, time, booking, costs etc)?
- impact of involving an interpreter on relationship with woman?
- how was confidentiality explained to woman and interpreter?
- own experience as interpreter (+/-)?

8 View of HCPs' role and needs in caring for migrant women with histories of DV

- to what extent do they think HCPs can help migrant women with DV?
- are HCPs the right professionals to be doing this?
- who else (if anyone) can help?
- to what extent do they feel they can help migrant women?
- what help would they require in terms of training in order to help abused migrant women more appropriately?
- suggestions for improvements of existing IRIS training?

- **Any other issues**

Closure of interview

- briefly look through question sheet to check covered all questions (quick check, if missed, return to questioning or ask expand on previous answer)
- info: end of interview, ask anything else they feel they'd like to say or add?
- ask whether any questions that were of particular interest to them (If so, which? and in what ways?)
- ask the participant if there were any questions that were confusing or difficult to answer? (if so, which? and in what ways?)
- check interview experience and how they are feeling
- withdraw consent?
- thanks (turn off the digital recorder)
- give voucher
- offer the participant the participant support sheet (if appropriate).

Appendix 23. **Participant data form for women**

EMiNA Study

University of BRISTOL

Participant data form for women

Study ID	
Name	
Chosen pseudonym	
Gender	
Number of children	
Gender of children	
Age of children	
Address	
Age	
Country of origin	
Native language and other languages spoken	
Arrival in Britain	
Immigration status	
Religion	
Benefits	
Income range	Under 10K, 10-20K, 20-30K, more than 30 K

Appendix 24. **Participant data form for professionals**

EMiNA Study

University of BRISTOL

Participant data form for professionals

Study ID	
Name	
Chosen pseudonym	
Gender	
Profession	
Qualified	
No of years in practice/organisation	
Address of organisation	
Age	
Country of origin	
Native language and other languages spoken	
Arrival in Britain	
Religion	

Appendix 25. **Transcriber guidelines**

General Points:

Note the interviewer as 'INT' and the interviewee as 'RES' (enter a tab between the denoting letter and the text)

Start each turn/talk on a new line

Time stamps

Interrupted speech	End speaker 1's speech with a dash and restart it with a dash, for example:- R I just find it, well, heartbreaking- A Yeah R -because she wouldn't speak to us for two years
Overlapping speech	Use square brackets, for example:- A Well I was just wondering how that... [made you feel?] R [It was incredibly] hard at the beginning
Reported speech	Use speech marks, for example:- R... he said, "Well I don't think so"
Non speech sounds	Add in parentheses, for example:- (laughs) and (telephone rings)
Pauses in speech	(1) mark with three stops,
Mispronounced words or colloquialisms	Leave as said, for example:- 'kinda' and 'cos'
Repetitions and 'fillers'	Include in the transcript as far as possible For example: - 'hmm' and 'um'
Names/places/dates	Leave in for anonymisation post-transcription
Incomprehensible speech	Note in square brackets: [~~]
Cut-off or truncated words	End with a dash, for example:- R he wen-, he went off provide a transcript to include additional indicators such as non-verbal responses, interruptions or distinct voice quality e.g. [angrily]

Appendix 26. **Transcriber confidentiality agreement**

Confidentiality Agreement

Made on 19 February 2013

Between

And Nadia Khelaifat ***("The Client")***, Centre for Academic Primary Care, NIHR School for Primary Care Research, School of Social and Community Medicine, University of Bristol, Canynge Hall, 39 Whatley Road, Bristol BS8 2PS

It is a strict condition of this agreement that any confidential information received concerning *("The Client")* its staff, clients, suppliers or others with whom the organisation may trade is not divulged to any third party.

The information contained on the audio recordings in relation to *("The Client")*, the identity of the staff members concerned, the identity of *("The Client")*'s clients as well as any matters discussed or raised on the audio tapes (this list is non-exhaustive) is strictly confidential to *("The Client")* and shall be referred to in this Agreement as "Confidential Information".

must not divulge any of the Confidential Information to any person or company who is not a party to this agreement without the prior written consent of *("The Client")* unless required to do so by law. If such disclosure is required by law, then the shall promptly give notice of such disclosure to *("The Client")*.

No use may be made of the Confidential Information, documentation, audio recordings or any other information other than for the purposes of the Services or otherwise as instructed in writing by *("The Client")*.

shall make no direct or indirect contact with *("The Client")*'s clients suppliers or staff in respect of the Services, other than specifically authorised in writing by *("The Client")*.

acknowledges that it will be in possession of 'Personal Data' as described in the Data Protection Act and the shall comply with the provisions of the Data Protection Act 1998.

This Agreement is personal to shall not assign this Agreement; nor shall sub-contract or delegate to any person any of its responsibilities under this Agreement.

This obligation of confidentiality shall continue to apply without limit in time after the termination of the contract.

I have read and understood the Terms and Conditions of this Agreement as set out above (which I acknowledge having received) and I hereby accept them in total.

Signed: ..... **Signed:** **Nadia Khelaifat**

(On behalf of "The Client")

Date: **19 February 2013** **Date:** **19 February 2013**